Behind Closed Doors
Acute Mental Health Care in the UK

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The current state and future vision of acute mental health care in the UK

PRODUCED IN ASSOCIATION WITH:

rethink severe mental illness
SANE
The zito Trust
NAPICU National Association of Psychiatric Intensive Care Units

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Table of Contents

Introduction

There are too many people in our psychiatric units, particularly those – like the psychiatric intensive care units (PICUs) – that work with those most severely ill. Advances in the understanding of severe mental illnesses, like schizophrenia and bipolar affective disorder (manic depression), and advances in holistic treatment make the recovery of a full and meaningful life an achievable possibility for hundreds of thousands of people who, in past years, might have expected to spend long periods in hospital. The majority of people with severe mental illness live successful lives in the community. However, these lives are too often interspersed with unwelcome stays in hospital.

As this report shows, there is a crisis in psychiatric in-patient care with wards over-crowded, treatment taking place in "bleakness and squalor" and staff left feeling demoralised and unsupported. Since 1998, when the government embarked on an ambitious and continuing reform of mental health, over 650 strategies, frameworks, guidelines, guidance notes and protocols have been issued. There has even been more money pumped into the system, but quite how much and where it has gone is up for debate. Much has improved. New advanced services have opened in many areas. The National Institute for Clinical Excellence has called for the end to the postcode prescribing of the most modern medicines for the treatment of schizophrenia and has started a review of the treatment of bipolar disorder. People using mental health services and their carers are increasingly involved in the planning and delivery of local services and routinely contribute to the work of NICE and other national agencies such as the National Institute for Mental Health in England. There is a growing understanding amongst clinicians that people no longer want to be "done to" but want to devise their own care and treatment, drawing on professionals as an expert resource. Service users are making more use of advance directives and advance statements. Although advance directives and advance statements have yet to be granted a status in law, they do allow people to set out when well how they want to be treated if they become so ill that they can no longer express their wishes.

But much has still to improve. The NICE call to end postcode prescribing has not been heard everywhere. The involvement of service users and carers is too often experienced as a paper exercise. Shortages of psychiatrists, specialist nurses and other support staff narrow the treatment choices on offer. The general public's understanding of severe mental illness is still shrouded in prejudice, ignorance and fear while the number of people being "sectioned" – compulsorily treated under the Mental Health Act – is still rising.

Why is there such a manifest gap between the possibilities offered by advances in understanding and treatment and the experiences of people "sectioned" into hospital? In the following pages, contributors give their varying perspectives on the crisis, but all come to the same conclusion – it doesn't have to be like this. What we have all learnt from the present reform programme is that more money, spent on the front-line and on services developed with the active involvement of service users and carers makes a real difference to people's lives. For Behind Closed Doors, that means reducing the numbers of people subject to compulsion, reducing the length of stay in hospital, improving the experience of service users and hospital staff and making sure that the most modern understanding of mental health and treatment options are available.

Our thanks go to the service users, carers and staff whose experiences have made this report both necessary and possible, to all the organisations who have contributed their understanding and to Lilly whose financial support has made this report achievable.

Paul Corry
Head of Policy and Campaigns, Rethink

Section 1:
The Lie of the Land

> "It would be surprising if a public service was tolerated when it was feared by its customers (whom it puts at risk), unable to show evidence of its effectiveness and paying its staff uncompetitively. It would be astonishing if, nevertheless, such a service could not cope with demand. Yet this is a recognisable picture of acute mental health care in the NHS."[1]
>
> **MATT MUIJEN, CHIEF EXECUTIVE, THE SAINSBURY CENTRE FOR MENTAL HEALTH**

At some point in their lives, most people who experience severe mental illness – principally schizophrenia or bipolar disorder (previously known as manic depression) – will be admitted to hospital. The vast majority are admitted to open wards but, where behavioural disturbance is such that a higher level of security and/or intensive intervention is required, admission to a PICU (psychiatric intensive care unit) or secure unit may be warranted.

HIGH SECURITY HOSPITALS The three special hospitals: Broadmoor, Rampton & Ashworth

MEDIUM SECURE UNITS Regional secure units

LOW SECURE UNITS
Semi-secure high dependency units for long-term patients

PSYCHIATRIC INTENSIVE CARE UNITS (PICUs)
Highly structures locked units for short to medium term intensive care

OPEN ACUTE WARDS

FIGURE 1 PSYCHIATRIC INPATIENT CARE FACILITIES IN THE UK

According to the Department of Health, the purpose of an acute psychiatric inpatient service is to provide a *"high standard of humane treatment and care in a safe and therapeutic setting for people in the most vulnerable stage of mental illness."*[2] The National Service Framework (NSF) for Mental Health stipulates that "each service user (patient) should have timely access to an appropriate hospital bed in the least restrictive environment possible, consistent with the need to protect them and the public, as close as possible to home."[2]

The reality falls woefully short of this ideal. In 1998 the Sainsbury Centre for Mental Health undertook a major and much publicised research project,[3] following over 200 people though their experience of inpatient care. Their report described wards across the country operating with excessive bed occupancy rates in outdated, neglected facilities not designed to cope with a large number of people in crisis. It told of people left for hours on end with nothing to do, lack of privacy, lack of basic amenities, illicit drug use and inadequate contact with staff. Since then, while numerous well-intentioned government initiatives have been set up to address this situation, it appears that little real progress has been achieved.

Section 1: The Lie of the Land

The image of hospital as a place of last resort and the development of alternatives such as crisis homes and community teams has meant that the threshold for acute admission has risen over time.[1] The effect is that the populations of mental health wards today are, overall, more severely ill than the hospitalised populations of the past. It is also a disturbing thought that the number of acute inpatient beds in England has gone down but that demand for beds has risen. To cope with such demand, hospitals are forced to maintain waiting lists, to send some patients home on leave in order to free up beds for others and to transfer patients to hospitals outside the area, often in the private sector. Thus, in inner London in January 1999, there were 241 patients on leave (123 of whom urgently needed a hospital bed) and a further 80 people in hospitals far from their homes.[4]

Rising section rates

The majority of mental health service users (patients) admitted to hospital are there compulsorily under the 1983 Mental Health Act (in which the specific powers and circumstances are outlined under various sections, hence the term 'sectioning'). Compulsory detention is carried out when an individual with a mental disorder is judged to be jeopardising their own health or safety, or posing a risk to others.

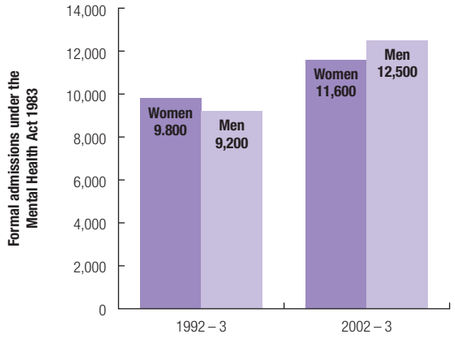
Section	Authority Provided	Recommendations Required	Duration
Section 2	Detention in hospital for assessment and initial treatment	Two medical; one social worker	Up to 28 days (may then convert to Section 3)
Section 3	Detention in hospital for treatment (when the diagnosis is clear)	Two medical; one social worker	Up to 6 months initially (renewable for a further 6 months and then for a year at a time)
Section 4	Emergency admission to hospital (can then convert to a Section 2 if second medical recommendation is made)	Two medical; one social worker	Up to 72 hours
Section 136	Enables a police officer to remove an individual from a public place to a "place of safety" for assessment as to whether an admission section (2 or 3) is warranted	Police officer's judgement	Up to 72 hours

FIGURE 2 KEY SECTIONS OF THE MENTAL HEALTH ACT 1983

In November 2003, new figures released by the Department of Health revealed a rise of nearly 30% in the number of people detained under the Mental Health Act over the past decade.[5] This increase was double for men compared with women.[5]

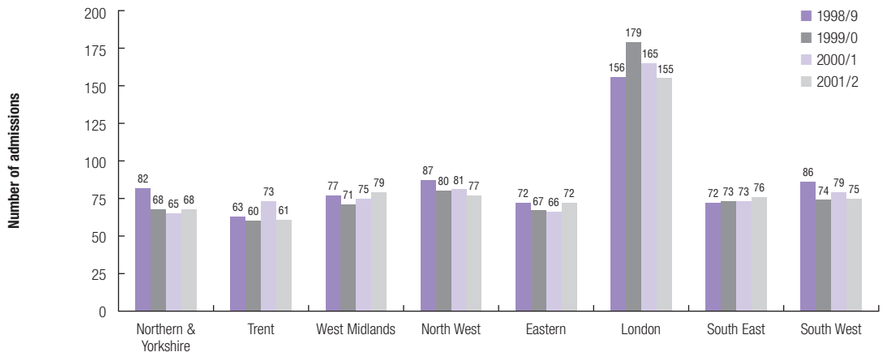
Section 1: The Lie of the Land

FIGURE 3 RISE IN SECTION RATES 1992 – 3 TO 2002 – 3[5]



Meanwhile, research by the King's Fund over a five year period (1998 – 2002) showed that the rate of compulsory admission was twice as high in London as in any other region in the country.[6]

FIGURE 4 COMPARISON OF COMPULSORY DETENTIONS 1998 – 2002 IN EIGHT UK REGIONS[6]



Source: www.doh.gov.uk/pulic/work_health_care.htm#menthealth

According to Rethink, likely causes for this escalation in section rates include the lack of effective community mental health services, leaving vulnerable people adrift and unsupported, while SANE comments that the bleakness and squalor of many acute wards acts as a deterrent to voluntary admission:

> "These figures are a wake-up call. Our own research has shown that one in three people are turned away from services when they seek help. People are often left to become so ill that they find themselves under a compulsory detention order when early intervention could have prevented this traumatic experience."
>
> **RETHINK**

Section 1: The Lie of the Land

> "There would be no need to have people detained against their will if the conditions in which they received voluntary treatment were made tolerable and humane. So dreadful are many wards that patients say – and psychiatrists confirm – that the only way they will stay in hospital is if they are sectioned under the Mental Health Act."
>
> **MARJORIE WALLACE, SANE**

The observed rise in section rates may also be related to the ongoing reduction in psychiatric beds since a shortage of beds could create two types of pressure:[7]

- Pressure not to admit patients, conceivably leading to deterioration to the point where sectioning is required;
- Pressure to discharge patients early, possibly resulting in a greater likelihood of compulsory readmission

A further contributory factor to the rising section rate is that health practitioners have become more risk averse, driven by a spate of inquiries into homicides committed by people with mental illness and the consequent preoccupation of successive governments with public safety.[7] A particularly steep rise in section rates was seen in 1994 – the year of the highly publicised case of Jonathan Zito, who was fatally attacked by a mental health service user with severe paranoid psychosis. The problem of course is that those who pose a danger to society represent only a tiny fraction of people with mental illness, while many others may find themselves the victims of a system that is 'taking no chances.'

> "The current system is designed to deal with crises, rather than avoid them. The aim should be to keep people out of hospital, through providing an effective community care infrastructure."
>
> **JAYNE ZITO, THE ZITO TRUST**

Ethnic inequalities

What is also clear is that detentions are significantly more common among black people, pro rata, than among whites. Some reports claim the section rate for black people to be twice as high as for white people, while others have found it to be as much as six times higher.[8] Possible reasons for this over-representation of black people within the sectioned population include an over-diagnosis of severe mental illness (in particular schizophrenia), mistrust of services (leading to delay in seeking help) and a greater disinclination to persist with taking medication.[8]

Sadly, however, the blight of institutional racism cannot be discounted as an additional factor. Recent research by Rethink found that 88% of black and minority ethnic service users had been forcibly restrained under a section of the Mental Health Act compared with 43% of whites and that, in the community setting, black and minority ethnic individuals were 40% more likely to be turned away when they asked for help than their white counterparts. Clearly, mental health services whose catchments contain high numbers of black people must make appropriate provision for them and aim to ensure a corresponding ethnic mix among staff.[8]

Section 1: The Lie of the Land

> "The government knows what the problems are. Its own reports have made the problems clear for years. What is needed now is action – action that matches the scale of the problem."
>
> **RETHINK**

The revolving door

All too often, people with severe mental illness discharged from hospital are back again within only a few weeks or months, confirming the so-called "revolving door" of acute mental health care.

FIGURE 5 READMISSIONS TO PSYCHIATRIC INPATIENT SERVICES

Admitted to same service in past 12 months	**40%**
Admitted to same service in past 90 days	**20%**
Admitted to same service in past 6 weeks	**13%**

(AS FOUND BY THE 1998 SAINSBURY CENTRE REPORT)[4]

Added to the fact that a tendency to relapse is – for a significant number of people with schizophrenia and bipolar disorder – an inherent feature of their illness, this high rate of people returning to acute care in a state of crisis may also indicate that many service users find themselves prematurely discharged from hospital and many are subsequently inadequately supported by struggling community services.

The new draft Mental Health Bill

The Mental Health Act of 1983 – under which section rates have risen so sharply – is currently under governmental review, with a new draft Mental Health Bill published in June 2002. A full assessment of the specifications and implications of the new draft Mental Health Bill is beyond the scope of this report but the prevailing opinion amongst advocacy and professional organisations is that the new Bill will make a bad situation worse. It is feared that the proposed widening of treatment criteria for mental illness will not only increase the number of people detained in hospital even further but will also enforce compulsory treatment in the community, deterring vulnerable people from seeking help and undermining years of work by the government and mental health campaigners to reduce the stigma of mental illness. A range of lobbying campaigns and protests, led by the Mental Health Alliance, are currently underway, condemning the draft Bill as "regressive" and "a danger to human rights." Due to these campaigns the government has promised a new draft Bill this year, which will receive parliamentary scrutiny ahead of the normal legislative process.

> "We hope the government will bring forward a new Mental Health Bill which focuses on the positive rights of patients and families rather than extending compulsion. Already overpressed and depleted mental health professionals must not be diverted into underpinning laws of coercion instead of giving essential care and treatment."
>
> **MARJORIE WALLACE, SANE**

Section 2:

Admission: The First Few Minutes

There are numerous reasons for admitting a mentally ill person to hospital. They may be in a state of extreme confusion and distress, they may exhibit marked disinhibition and loss of control, or, at the other end of the spectrum, they may have withdrawn completely and spiralled into profound self-neglect, refusing to wash or leave their room. In many cases, substance abuse complicates the picture. Whatever the situation, admission to hospital – particularly for the first time – can be a desperately frightening experience.

The patient's perspective

Angry, confused and bitterly resentful, the newly detained person frequently sees their surroundings as punishment, the hospital as a prison and the staff as warders. Why this incarceration, this coercion, this conspiracy? The target for their rage is likely to be the next visitor or the nearest nurse. Relatives may find themselves on the receiving end, for they are the betrayers – they have connived with the authorities. Emotions may range from fury through deep suspicion to terror and bewilderment beyond measure. If this is a first admission it could well be perceived as the stuff of nightmares, the worst thing that has ever happened to them, the "slippery slope" into institutionalisation. If it's their fourth time, they could be overwhelmed by frustration, their misery and humiliation making them uncooperative and volatile.

The physical environment of the ward can greatly amplify the tension of the first encounter. If, as is so often the case, it is noisy, dirty, smoky, cramped and overcrowded, the patient's sense of punitive confinement escalates.

The staff's perspective

Meanwhile the nursing staff have their own preconceptions. In a survey[9] more than 90% of those interviewed said they had at some point felt endangered – or perceived danger to their co-workers – when dealing with a patient in the throes of an acute episode.

Violent and intimidating behaviour is most strongly linked to abuse of street drugs, which is unfortunately a factor in up to half of people with severe mental illness.[10] In such circumstances the empathy that many nurses feel for newly admitted patients may take a back seat to concerns for personal safety.

> "Naturally, the staff perceive themselves as "the good guys" and as "caring professionals." Not all can see themselves through the eyes of the patient, who may have a very different perspective".
>
> **DR ZERRIN ATAKAN, BETHLEM ROYAL HOSPITAL**

There can be few more highly charged scenarios than this. And for the patient it comes on top of the harrowing symptoms with which they had been struggling prior to admission.

Acute manifestations of schizophrenia and bipolar disorder

People in the acute phase of schizophrenia show a wide variety of symptoms – from total social withdrawal and self-neglect through to delusional beliefs, auditory hallucinations (hearing voices) and unpredictable erratic behaviour. For them the world is a strange and hostile place, full of marshy ground and hidden dangers. In the case of bipolar disorder, an acute "high" brings feelings of invincibility and restlessness – risks and barriers cease to exist, reckless decisions are made, everything speeds up – but this soon gives way to confusion, disorientation and fear.

Stabilisation for acute agitation

In both disorders, a proportion of people will arrive in hospital in a state of acute agitation, displaying particularly impulsive, hostile and aggressive behaviour (sometimes brought on by the experience of sectioning). Since acutely agitated individuals can pose a serious threat both to themselves and others, urgent stabilisation/tranquillisation is needed. In such extreme circumstances, this frequently means an intramuscular injection, since oral medication may be rejected by the patient and, even if accepted, might not work quickly enough.

Holding down a person and forcibly injecting them with powerful drugs is possibly the most torrid aspect of psychiatric care today, bringing to mind the days of straitjackets and padded cells. For nursing teams it can be deeply upsetting; for first-time patients catastrophic – but it also marks a seminal moment: their first encounter with antipsychotic drugs, the medicines they may need to "make friends with" for the rest of their lives.

Section 3:

The Importance of Effective Treatment

Standard treatment

Today, the choice of antipsychotics is between the so-called 'typical' antipsychotic drugs, such as haloperidol and chlorpromazine, which have been around since the 1950s, and the newer 'atypical' drugs such as olanzapine, risperidone and quetiapine.

Although the two drug classes are both effective in achieving control of schizophrenia symptoms such as delusions and hallucinations, the typicals exact the penalty of a high rate of distressing side effects known as "extrapyramidal symptoms":[11]

Parkinsonism:	Stiffness, shakiness and tremor characteristic of Parkinson's Disease
Acute Dystonia:	A severe spasm of the limbs or of the face and throat that makes people feel as though they are choking
Oculogyric Crisis:	A form of acute dystonia in which the patient's eyes rotate upwards or to the side, remaining fixed in that position for lengthy periods of time
Akathisia:	Continual restless leg movements
Tardive Dyskinesia:	Disfiguring involuntary movements of the mouth and tongue associated with long-term treatment

Before January 2004, the only injectable atypical antipsychotic was a long-acting "depot" injection of risperidone given every two weeks for maintenance therapy. The only injectable drugs available for acute care (rapid stabilisation) in the UK were the old-style 'typical' drugs. Thus, on top of the trauma of sectioning and an enforced injection, patients had to endure the misery of extrapyramidal side effects, with muscular stiffness, shaking and spasms. The situation was compounded further by the fact that some agents (e.g. chlorpromazine) are highly sedating while others (e.g. haloperidol) are slow to act. Not uncommonly, repeat double-dose injections of haloperidol – or even intravenous injections – have been given to speed up the effect, a practice that not only risks intolerable side effects but is also hazardous. Even when given at normal doses, rapid tranquillisation can be associated with loss of consciousness, breathing difficulties and seizures, requiring a high level of skilled nursing care.[12] It is small wonder that the Royal College of Psychatrists' 1998 *Guidelines on the Management of Imminent Violence* counselled caution when using medication for rapid tranquillisation due to "possible damage to the patient/clinician relationship."[12]

New developments

At the beginning of 2004 came a welcome development: injectable olanzapine was launched – the UK's first fast-acting, atypical antipsychotic to be available in a form suitable for dependable control of acute agitation. Clinical trials had shown that injectable olanzapine matched the effectiveness of haloperidol in stabilising acute agitation in both schizophrenia and bipolar mania, with fewer and less severe side effects.[13, 14, 15] The trials had also found that it acted more quickly.[13, 14, 15]

Sparing a vulnerable patient additional distress at such a traumatic time is an obvious advantage but perhaps the most significant implication of the launch of injectable olanzapine is the fact that a patient's experience of treatment in the acute phase of their illness can act as a 'blueprint' for their future attitude towards therapy and their trust of healthcare professionals.[16] Even if patients stabilised with intramuscular haloperidol or chlorpromazine are subsequently prescribed oral atypicals, the damage to their longer-term relationship with care providers – and hence to their eventual health outcome – may have been done with that first syringe.

This view was echoed by nearly 90% of a sample of UK psychiatrists interviewed last year.[9] In the same survey, 86% of respondents felt that the availability of an injectable atypical would be an improvement, or vast improvement, on the options available at the time,[9] helping to minimise the trauma of that all-important first encounter with medication.

> "Atypical antipsychotics changed the face of schizophrenia management, but for many years we were unable to bring their benefits to acutely disturbed patients with psychotic illness. Until very recently, we had no choice but to use a typical antipsychotic such as intramuscular haloperidol in such patients, even whilst they were on an oral atypical. This sort of "polypharmacy" is not desirable. Now, with the launch of injectable olanzapine, typical agents can, in many cases, be avoided altogether."
>
> **DR ZERRIN ATAKAN, BETHLEM ROYAL HOSPITAL**

Once stabilised, the aim of management is for patients to start oral medication as quickly as possible. However in those shaky first few days, detained people may still be wary, mistrustful and reluctant to swallow tablets. In such circumstances, 'oro-dispersible' formulations of either olanzapine or risperidone – which melt more or less instantaneously within the mouth – may be helpful.

Section 3: The Importance of Effective Treatment

NICE: Importance of using ‘atypical’ antispychotics

In June 2002 the Government’s medicines watchdog NICE (the National Institute of Clinical Excellence) told healthcare professionals that ‘atypical’ antipsychotics should be first choice drugs for people with schizophrenia,[17] despite the fact that they cost 10 – 20 times as much as the crude and outdated ‘typical’ drugs. However, NICE had the vision to see that the higher costs of atypicals were more than offset by reductions in inpatient stays. Part of the reason for the greater clinical success of atypicals is the strong relationship between patient satisfaction with their drug treatment, their persistence with it and ultimately a reduced risk of relapse.

It has been shown that, while psychiatrists tend to regard symptom control as a more important objective than freedom from side effects, the reverse is true for patients and relatives, underlining the importance of participation by patients in clinical decision-making.[18]

> Quality of life has emerged as the ideal of modern medicine. In this new paradigm, patients are no longer regarded as the passive recipients of treatment, but as active participants in their own care.
>
> **DR JONATHAN HELLEWELL, CONSULTANT PSYCHIATRIST, MANCHESTER**

Many patients on typical antipsychotic drugs not only report extrapyramidal side effects but also a sort of emotional ‘blunting’ or ‘dulling down’ known as ‘neuroleptic dysphoria.’ This phenomenon is at least part of the reason why people stop taking these medicines and it may also make them more likely to abuse illicit drugs.[18] In contrast, most people on atypical drugs find that, with side effects that are relatively minor and manageable, they can start to derive real and meaningful benefit from the antipsychotic effect.

So is the NICE directive being implemented? Ongoing national monitoring conducted by the Zito Trust has shown that – despite the three-month deadline imposed by NICE in June 2002 – uptake has been slow.

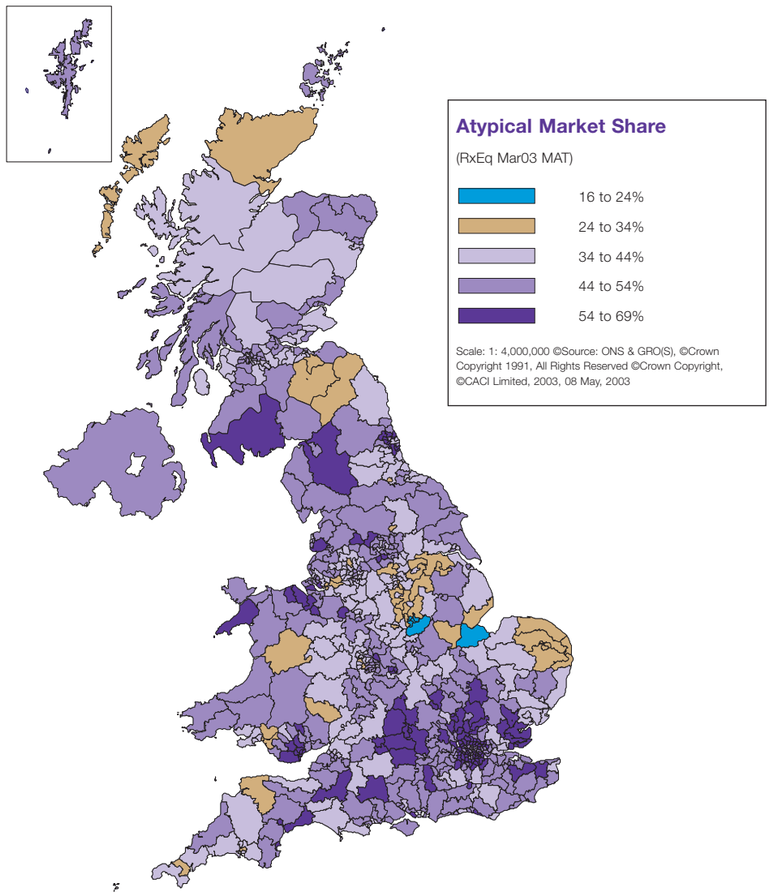
> People with severe mental illness are still being treated like second class citizens, despite the NICE ruling that was supposed to ensure they were no longer forced to take cheap, unsuitable medicines.
>
> **RETHINK**

> Research has shown that over 80% of psychiatrists would choose an atypical rather than a typical drug for a loved one. Why are these drugs still being withheld when so many people could benefit from them?
>
> **MICHAEL HOWLETT, THE ZITO TRUST**

Section 3: The Importance of Effective Treatment

Currently, implementation of the NICE advice varies widely from region to region, leading to the phenomenon of ‘postcode prescribing.’ Although these findings apply primarily to mental health prescribing in the community, it can be assumed that they reflect the situation in hospitals too.

FIGURE 6 REGIONAL UPTAKE OF NICE GUIDANCE ON ATYPICALS (MARCH 2003)



> In the USA, over 90% of people with schizophrenia are prescribed the newer medications. Why should we in this country deny people with this cruel illness, who are often desperate and suicidal, the chance of a better life?
>
> **MARJORIE WALLACE, SANE**

Section 4:
Life on the Ward

While there are some excellent inpatient services with dedicated professional staff, there is also incontrovertible and compelling evidence – particularly from service user feedback – to indicate that all too often the experience of acute inpatient care is felt to be neither safe nor therapeutic.[2] For many service users, previous experience of acute inpatient wards is so negative that they avoid contact with mental health services when acutely ill for fear of a repeat admission.[2]

Service users report serious concerns regarding:[2]

- A poor physical and psychological environment for care, including lack of basic necessities and arrangements for safety, privacy, dignity and comfort
- Insufficient information on their condition, their treatment and on how the ward and service operates
- Lack of involvement and engagement in the planning and reviewing of their own care and in how the ward is run
- Inadequate staff contact, particularly on a one-to-one basis
- Insufficient attention to the importance of factors like ethnicity, gender and protection from harassment/abuse
- Lack of 'something to do,' especially activity that is useful and meaningful to recovery. This is a recurring theme that has been described as a sort of 'suspended animation'.

The environment

The 1998 report of the Sainsbury Centre for Mental Health[3] (and many others since) highlighted cramped, dirty and run-down conditions; accommodation that is poorly lit, poorly ventilated and includes no quiet, private or no-smoking areas; unacceptably poor hygiene, floors strewn with litter and cigarette ends and the constant intrusive blare of a TV or radio.

> "Visiting friends and relatives were appalled. The sheer squalor around them seemed to reflect the rock-bottom state into which their loved ones had plunged, and at the same time symbolise the negligible value that the state placed on them."
>
> **MAGNUS LINKLATER, JOURNALIST & BROADCASTER**

Nothing to do

In addition, most researchers report an atmosphere of 'institutional aimlessness'. A study conducted by social work students in Merseyside commented that patients "have nothing to do but watch TV and are regularly moved around by cleaning staff."[4]

> "Like everyone else, inpatients need something to occupy them: boredom fuels disturbance, promotes conflict with staff and other patients and increases the risk of violent behaviour."
>
> **DR ZERRIN ATAKAN, BETHLEM ROYAL HOSPITAL**

> "Boredom makes people worse – more ill – situations escalate in mental health units like they do in taxi ranks."
>
> **LAURIE BRYANT, IMPACT RESEARCH TEAM**

Structured programmes of social and recreational activity (such as occupational therapy, art therapy, physical exercise or music) are desperately needed, including at weekends when the atmosphere can be particularly 'flat.'

Engagement with staff

Having recovered from acute episodes of mental illness, some people do say that it was the nurses – or one nurse in particular – who "made all the difference" to them while in hospital. However others feel ignored by staff and deprived of the contact they need. Reports show that record-keeping, ward rounds and observations can inappropriately monopolise staff time and reduce their availability for therapeutic engagement. This situation is compounded by high staff turnover and an over-reliance on bank and agency nurses. The same problem applies to doctors. Over 400 consultant posts in psychiatry currently go unfilled. NHS consultants are stretched beyond tolerance, often making only infrequent contact with their patients. In some cases care is left to junior doctors, also stretched, and use of locums is far too high, a situation that at its worst in London.

> Here in the 'locum zone' continuity of care is a dirty word. Here you can be admitted under one psychiatrist and discharged two weeks later under another. Some locums are fantastic and really seem to care about their job but this does about as much good as a holey umbrella if they're gone by the time of your next appointment. Trust is one of the central factors in a therapeutic alliance. How can you trust your psychiatrist if you don't know who they are?
>
> **RACHEL STUDLEY, SERVICE USER (www.madnotbad.org.uk)**

Substance abuse

Recreational drug use is an enormous problem among psychiatric inpatients – particularly in London[10] – with crack cocaine and cannabis readily available from dealers who visit the wards. The overriding concern about this situation is that illicit drug use complicates treatment, prolonging lengths of hospital stay and increasing the likelihood of future relapse. Studies have shown that people with 'dual diagnosis' (co-existing mental illness and substance misuse) account for 30–40% of people with severe mental illness, spend twice as many bed days in hospital and are four times more likely to commit acts of violence than those with schizophrenia alone.[19] On 29 January this year, cannabis was reclassified from a Class B to a Class C drug. Worryingly, the accompanying government awareness campaign – intended to stress that cannabis remains an illegal drug – failed to point out the mental health dangers of heavy or prolonged cannabis usage in people experiencing – or at high risk of – psychosis.

Section 4: Life on the Ward

Ward culture

On some wards, low thresholds for formal observation, unnecessarily rigid rules and overly oppressive ward rounds result in a culture that is too controlling and custodial. As journalist Magnus Linklater[20] puts it: “the distinction between a hospital and a jail should be fundamental. Once that becomes blurred, the whole basis for therapy crumbles.” That said, systems must be in place to deal with conflicts, violent incidents, racial/sexual harassment and other forms of unacceptable behaviour. Wards needs codes of conduct negotiated with service users, provisions for “time outs” (taking patients to “cooling off” areas that do not have the connotations of being put in seclusion) and very clear policies on the appropriate use of physical restraint.

While all this makes for bleak and depressing reading, it should be pointed out that there have been some notable success stories and ‘islands’ of innovative practice.

> “Small things make a big difference, not just because of practical needs being met but because of how the service values you... that lightbulb changed, a lick of paint on the ward, being asked your opinion.”
>
> **SERVICE USER, SOUTH BIRMINGHAM**

Section 5:
Psychiatric Intensive Care

One area of acute mental health care that has seen a level of progress and innovation in recent years is psychiatric intensive care. Psychiatric intensive care is for compulsorily detained patients who are in an acutely disturbed phase of a serious mental disorder and cannot be managed effectively and safely in a general open acute ward. Generally these are individuals who display a significant potential for aggression, violence, self-harm or vulnerability (due to sexual disinhibition, for example). Ordinarily, length of stay doesn’t exceed 8 – 12 weeks.

Psychiatric intensive care units (PICUs) are highly structured locked units with high staff to patient ratios, to allow a prompt response to crises and ensure that users are given the care and support they need. In 1998 NAPICU, the National Association of Psychiatric Intensive Care Units, was launched with the aim of raising standards of care for severely ill detained patients and developing psychiatric intensive care as a speciality in its own right.

> “Locked wards were traditionally a ‘backwater’ of psychiatric care, evoking images of the bad old days of asylums and dehumanising conditions. The aim of NAPICU is to create a psychiatric intensive care service fit for the 21st century.”
>
> **DR STEPHEN PEREIRA, CHAIR OF NAPICU**

Today, the psychiatric intensive care ‘movement’ in the UK is much further ahead than in any other country including the US, mainly through the vision of a few pioneering individuals. In no other country are there National Minimum Standards for PICUs[21] (developed by a multidisciplinary team including service users) or a textbook dedicated to psychiatric intensive care. NAPICU is also establishing formal modules on intensive care psychiatry within a Master’s Degree Course at South Bank University and at Guy’s, King’s & St Thomas’ School of Medicine.

Added to this there are systems in place to ensure that positive change occurs in PICUs across the country in a consistent manner. As of May 1st this year a national coordinator (funded by NIMHE – the National Institute for Mental Health in England) will be in place to work with the 15 units that could benefit most to ensure they attain their full potential as future centres of excellence.

> “We have invested in education, research, practice development, a regular meetings forum and national policies. We are continuing to promote service user empowerment. We have now moved beyond the paperwork stage and are beginning to see real change happen.”
>
> **DR STEPHEN PEREIRA, CHAIR OF NAPICU**

Section 6:
Back to the Community

Inevitably, pressure on beds has meant that many patients are discharged from hospital before they are ready. What is more, the Sainsbury Centre's 1998 report found that discharge arrangements were often dealt with in an ad hoc way during ward rounds, with only one third of patients given a dedicated meeting to plan for leaving hospital.[3,4] Most patients had no idea that they were to be discharged until a few days before they left and had little involvement in discussions about their future. Involvement of carers and community staff – so vital for the support of the person as they try to reintegrate – was also limited. In addition, while some patients are discharged from hospital prematurely, those in other areas may remain in hospital far longer than they need to because of a lack of community services or supported housing.

According to the Department of Health, the need for more investment in alternatives to inpatient admission (via initiatives called 'assertive outreach,' 'crisis resolution' and 'respite care') is recognised and programmed in as part of the National Service Framework and NHS Plan implementation arrangements. These initiatives are meant to close the gap between hospital and community, providing the treatment and support that is needed long after discharge. In some areas, these services are coming on stream but many remain underdeveloped, especially in London where aftercare has been described as "more of a concept than a reality." Thus, many patients are discharged from hospital to a fragmented, inadequate, patchy community set-up, ill equipped to meet their continuing needs. No wonder that revolving door keeps spinning.

> "We are concerned that the system still allows authorities to wash their hands of the most difficult cases without a guarantee that the patient will receive appropriate supervision outside hospital. If discharging panels are making decisions on partial information – and failing to pass on even that information to those responsible for community care – tragedies will happen."
>
> **MARJORIE WALLACE, SANE**

Section 7:
A Vision for the Future

NHS Mental Health Czar, Professor Louis Appleby recently defined what a quality mental health service should look like:[22]

A quality service would have six main elements:

1. It would treat patients and service users with dignity, creating the right environments for them to recover from illness and being guided by their views on how services should develop.
2. It would recognise the skills of families acting as carers, routinely welcoming them into care plans and responding when they are worried.
3. It would link service activity to need, ensuring that acutely ill people receive urgent access to care.
4. It would make the best and most effective treatments available.
5. It would emphasise the safety of patients themselves (since every year in England there are over a thousand suicides by people currently or recently under mental health care) as well as that of families, staff and the general public.
6. It would be delivered by a workforce that is both skilled and motivated.

Clearly, hospital wards should be places where service users have their needs actively assessed, planned and provided for, not simply dumping grounds for those too ill to look after themselves. In addition, planning for discharge and aftercare should be part of the initial care plan – hospitalisation must be a means to an end and not an end in itself.

> "Inpatient services must be conceived as stepping-stones to inclusion, not departure points for exclusion. The ultimate aim is participation in the mainstream of society for all who desire it"
>
> **"CREATING ACCEPTING COMMUNITIES" REPORT OF THE MIND INQUIRY 1998 / 9.2**

And involvement of end users in developing and shaping acute services is not only desirable but mandatory. They have the kind of knowledge and insights that can't be gained from textbooks, from surfing the net or even from working on the wards. They know what has helped them and what has not. They have unique insights into the holes in the system meant to support them, and may even have views on how to fill them. What is more, if the wider public see them helping to structure care services and being respected by mental health professionals, what better way to challenge the stigma of mental illness?

There is no doubt that some of the government's initiatives in the field are a step in the right direction. But it will take more than good intentions to reverse the years of failure and neglect that have characterised this country's treatment of people with mental illness. As we move towards the next election, politicians would do well to remember that millions of people with mental health problems – and their families – are voters too.

Acknowledgements and References

The organisations involved in the Behind Closed Doors campaign would like to thank the following for their time and assistance in the development of this report:

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Dr Zerrin Atakan, National Psychosis Unit, Bethlem Royal Hospital

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Supporting Organisations

Rethink

Rethink (previously the National Schizophrenia Fellowship) is the largest severe mental illness charity in the UK, dedicated to improving the lives of everyone affected by severe mental illness, whether they have a condition themselves, care for others who do, or are professionals or volunteers working in the mental health field. http://www.rethink.org

SANE

SANE is a leading UK charity concerned with improving the lives of everyone affected by mental illness. It campaigns to raise awareness and respect for people with mental illness and their families, improve education and training, and secure better services. It undertakes research into the causes of serious mental illness through The Prince of Wales International Centre for SANE Research, and it provides information and emotional support to those experiencing mental health problems, their families and carers through SANELINE. http://www.SANE.org.uk

The Zito Trust

The Zito Trust works towards the reform of mental health policy and law, provides advice and support to victims of community care breakdown, and carries out research into services for the severely mentally ill and disordered. http://www.zitotrust.co.uk

NAPICU

The National Association of Psychiatric Intensive Care Units was formed following the 1st National Conference on Psychiatric Intensive Care held in London in 1996 and organised by Dr Dominic Beer, Dr Stephen Pereira and Pharmacist Carol Paton. Following the conference a multi-disciplinary group of clinicians met and created what was is now known as NAPICU. NAPICU key aims are to advance psychiatric intensive care and low secure services, improve mechanisms for the delivery of psychiatric intensive care, audit effectiveness and to promote research, education and practice development within the speciality. http://napicu.org.uk/