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## **Abstract**

### **Title. Psychiatric wards: Places of safety?**

**Aim.** This paper is a report of a study to explore the experiences of service users on acute inpatient psychiatric wards in England regarding their feelings of safety and security whilst in hospital.

**Background.** In recent years the purpose and quality of provision delivered in acute inpatient psychiatric settings have been increasingly questioned. Studies from a service user perspective have reported that whilst some psychiatric inpatients feel safe and cared for, others see their time there as neither safe nor therapeutic.

**Method.** Sixty semi-structured interviews were conducted with psychiatric inpatients randomly selected from sixty psychiatric wards in England. The interviews were conducted over an 18 month period in 2004–2005. The interviews were analysed thematically.

**Findings.** A third of the respondents felt safe in hospital and felt supported by staff and other patients in times of need. However, anything that threatened their sense of security, such as fighting between patients, intimidation, bullying, theft, racism, and illegal substances such as alcohol or cannabis being smuggled onto the ward, made many of them feel insecure and unsafe. Psychiatric wards are still perceived by many as volatile environments, where service users feel forced to devise personal security strategies in order to protect themselves and their property.

**Conclusion.** It would appear that there remains much to do before research findings and policies are implemented in ways that facilitate all service users to derive the maximum benefit from their in-patient experience.

**Key words:** empirical research report, psychiatric wards, patient experience, risk management, hospital discharge, qualitative, interviews

## Summary to do

### **Introduction**

Since the 1950s, mental health reforms across Europe and countries such as the USA, Canada, Australia and New Zealand have resulted in the closure of long-stay psychiatric hospitals and the shift from institutional to community-based mental health care (Fakhoury & Priebe, 2002). The timing of legislation and pace of change has varied considerably both between different countries and within them and great diversity remains in the structure of mental health care services internationally (Goodwin, 1997; Becker & Vazquez-Barquero, 2001). However, despite this international trend of reform of the systems and locations of mental health care, no country has yet created a system that can function without ‘acute’ psychiatric wards for the treatment of people who require short-term hospital care when they are acutely mentally unwell (Quirk & Lelliott, 2004).

There is growing evidence at an international level that the quality of care on acute psychiatric wards is under threat, especially in those countries that have undergone the process of ‘de-institutionalisation’ (Quirk & Lelliott, 2004). Although some people undoubtedly receive high-quality care whilst in hospital, there is evidence to suggest that for some service users, their experience of spending time in an acute psychiatric ward is a

negative one (Baker, 2000; Glasby & Lester, 2005; Bramesfeld *et al.* 2007). Indeed some individuals report feeling unsafe whilst in hospital; Quirk and colleagues (Quirk, Lelliot & Seale, 2004;2006) have highlighted the worrying situation that some patients devise risk management strategies and take steps to avoid perilous situations and individuals, seek protection from staff and even feign improvement to get discharged.

The research presented in this paper represents the qualitative component of a larger mixed methods study, conducted over a three year period (2003-2005), to investigate the relationship between special observation, a containment method to prevent patients harming themselves or others, by allocating a member of staff to be within arms reach of an acutely unwell patient at all times (Bowers & Park, 2001) and self-harm, defined as the ‘intentional self-poisoning or self-injury, irrespective of motivation’ (Hawton, Hariss, Hall, Simkin, Bale & Bond, 2003). The rationale behind the mixed method design was the exploratory nature of the study, with the requirement to triangulate different sources of data (Cresswell & Plano Clark, 2007).

This paper reports on the qualitative component of the study which consisted of semi-structured interviews with 60 psychiatric inpatients, in hospital at the time of the study. The purpose of this qualitative arm of the study was to provide a more generalisable view of life on acute psychiatric wards in England, with the respondents in the study recruited from 60 different psychiatric wards in three different regions – the north west, central and southern England. Most previous research studies on this topic are qualitative in design and conducted in a small number of units, for example the ethnographic study conducted

by Quirk *et al* (2006) was conducted on three psychiatric wards. Therefore due to the design of the larger study the researchers were able to access service users in a larger number of psychiatric units than is usually possible for this type of enquiry.

## **Background**

In the UK over the last decade, policy documents and government reports have expressed increasing concern about the erosion of the quality of care provided in acute inpatient psychiatric settings (Sainsbury Centre for Mental Health, 1998; Department of Health, 1999;2002; Mental Health Act Commission, 2005). During this time there have also been a number of surveys and studies that have reported on service users' experiences of psychiatric wards. For example, a survey of mental health service users (Baker, 2000) reported that the experience of psychiatric hospital stay was characterised by ward environments that are un-therapeutic, dangerous and dirty, where illegal drugs are easily available, there is insufficient interaction with staff, and inadequate access to food, drink, bathing facilities, interpreters, telephones and fresh air. There is also evidence that some patients experience physical and psychological threats, actual violence and sexual harassment whilst on psychiatric wards in the UK (Mind, 2004; Royal College of Psychiatrists, 2005).

Seeking to contextualise modern psychiatric wards, Quirk *et al* (2006) draw on the seminal work of Goffman (1961), suggesting that wards have been transformed from 'impermeable' institutions, cut off from the outside world, to 'permeable institutions', where service users are free (and encouraged) to maintain external contacts during their

hospital stay. This permeability is viewed as having both positive and negative consequences. While isolation and the risk of institutionalisation are reduced, ease of access by visitors has enabled the traffic of illegal drugs, sometimes threatening the stability of the ward, and impeding the recovery of patients.

It has become evident that some individuals and groups of service users experience discrimination whilst in hospital. The inquiry into the death of David Bennett (Department of Health, 2005), a black patient who died whilst being restrained by staff in a medium secure psychiatric unit in Norwich, England, has fuelled concerns that people from black and minority ethnic groups experience indirect and institutionalised discrimination from the way mental health services are structured; whilst there is emerging evidence, as supported by the inquiry into the death of David Bennett, that some patients are verbally insulted because of their race. Further evidence of discrimination has been provided by the recent Healthcare Commission's (2007) report 'Count Me In'. This survey found that BME patients are three times more likely to be admitted to an inpatient unit, 19-38% more likely to be admitted involuntarily and 45% more likely to experience hands-on-restraint whilst in hospital.

Another issue of concern is the number of suicides by individuals whilst they are in hospital or shortly after discharge. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2006) found that 27% of all suicides in England and Wales between April 2000 and December 2004 were by current or recently discharged mental health patients (a total of 6,367 patients). Suicides by inpatients (still

in hospital) have fallen since 2004, but there are still a significant number of patient suicides (1,271 individuals) occurring within three months of discharge. It is known that some patients find leaving hospital stressful, particularly if they have felt secure and supported on their psychiatric ward, with discharge involving a loss of social support, both from staff and other patients. This 'discharge grief' may contribute to the high suicide rate particularly if aftercare is sporadic (Goldacre, Seagroatt & Hawton, 1993; Geddes & Juszczak, 1995).

## **The study**

### **Aim**

The aim of this study was to explore the experiences of service users who were hospitalised in acute psychiatric wards in England.

### **Methodology**

The research reported in this paper is the qualitative component of a larger mixed method study that used a triangulation design to collect both quantitative and qualitative data during the same time period. The whole study involved 136 acute psychiatric wards across England, in 26 NHS Trusts, in three different regions – south, central and northern England. The other research methods used in the study were: end-of shift reports on the frequency of self harm, special observation, violent incidents, absconding, rule breaking, alcohol/substance use, medication refusal, manual restraint and the use of PRN medication; questionnaires with staff and patients; and an economic evaluation of the cost



of special observation. More details regarding the overall methodology can be found in Bowers *et al* (2007).

### **Participants**

A random sample of sixty service users, who were in a psychiatric ward at the time of the study, was recruited. From a total of 136 psychiatric wards that participated in the overall study, twenty wards were randomly selected from each of the three regions included in the study, and one patient from each ward was then randomly selected for interview. Not all patients invited to participate in the study actually did so; eight were involved in other activities when the researcher arrived on the ward; six felt unwell and a further six refused to participate at the point of interview. Replacements for these individuals were identified using the same randomization procedure.

### **Data collection**

Face to face interviews were conducted in 2004-2005. A specially devised, semi-structured schedule was used to guide the interviews; the schedule was designed to elicit the participants' experiences of life on the psychiatric wards. The interview schedule was developed by a Service User Consultant (and member of project team) in consultation with Service User groups and the project team. Three Research Assistants, all experienced interviewers, carried out the interviews. Following reassurance as to the confidentiality and anonymity of interviews, all participants agreed to be tape recorded. The average length of each interview was 45 minutes.

## **Ethical considerations**

Ethical approval for the study was obtained from the North West Multi-centre Research Ethics Committee. All those participants approached were provided with a written information sheet and informed that they could refuse to take part, or withdraw at any time without it affecting their care. Sixty service users agreed to participate and signed consent forms. Each participant was allocated an anonymous code by the lead researcher in the region where the interview was conducted. Another member of the research team (JJ) conducted the data analysis and did not know the identity of the participants apart from their region and code number.

## **Data analysis**

The tape recorded interviews were transcribed verbatim and then entered into the QSR N6 software (QSR International, 2002). Thematic analysis was conducted deductively initially, according to the themes of the interview questions. This involved line-by-line analysis of each interview, coding each segment of data according to the interview questions which were set up as hierarchical 'nodes' in N6. This methodical method ensured rigour in the analysis process. During this process, new themes were identified, with similar phenomena being given the same general name in a 'constant comparative method of analysis' (Glaser & Strauss, 1967). During this process, some more prominent or 'higher order' themes began to emerge, reflecting the significance attributed to them by the respondents. This process led to the development of an 'axis' or 'hierarchy' of codes around the core theme of 'service users' experiences on acute psychiatric wards'.

## **Rigour**

Three researchers conducted the interviews in the three different regions where the wider study was conducted; it could be argued that this is less reliable than a single researcher conducting all the interviews. However, it is widely accepted that the qualitative interviewer is also a 'tool' of data collection and that each interview is a unique encounter and not replicable (Parahoo, 2006). In this study all three researchers were experienced in conducting qualitative interviews. To reduce potential problems of reliability they all received the same briefing and training and used the same interview schedule already described. During the course of the data collection the interviewers met together regularly to share experiences and promote a common approach to data collection. Furthermore, to enhance the validity of the findings, the transcripts were initially read by several members of the research team to check for accuracy. During the analysis process the emerging themes were discussed at length during regular research team meetings and an audit trail was kept to record key decisions and interpretations made.

Thirty-six men and 24 women participated in the study, with ages ranging from 19 to 81 (mean 43 years - one respondent did not give their age). The ethnicity of respondents was recorded according to the categories in the 2001 UK population census. Using these categories, 40 of our respondents (67%) were white; 11 (18%) were Black or Black British; six (10%) were Asian or Asian British, and three (5%) were from 'other ethnic

groups' Thirteen (22%) of the respondents were experiencing their first admission to an acute psychiatric ward.

For purposes of confidentiality, in presenting the key findings from the interviews respondents are referred to by a numbered code, preceded by a letter to represent the region where they were in hospital (South, Central or North). In the interview extracts, the following transcription notations have been used: (.) Pause; (pause) long pause; (...) some words missing.

### **Life on a psychiatric ward**

Contrary to the negativity of many of the reports and studies discussed in the background section of this paper, almost a third of respondents spoke positively about their stay on a psychiatric ward. Some described how it had helped them at a time of great distress, and many talked favourably about the staff. However, not everyone had a positive experience of being in hospital. A third spoke negatively about their stay, and others had found their experiences to be mixed. Some were unhappy simply about being in hospital:

“I don't like it. As simple as that, you're locked here 24 hours a day, you can't even go over the shops to get ciggys or papers or anything. There's nowt to do only sit and watch the telly, they don't do nothing, during the day, just lounging around you know, so that's not very good if you're mentally ill is it?” (N52)

As indicated by this quotation, about a third (28%) of respondents reported that life on a psychiatric ward was boring, a common experience reported by others (Antoniou, 2007; Binnema, 2004; Quirk *et al.*, 2004; Royal College of Psychiatrists, 2005).

### **Feeling safe on the ward**

Thirty-three respondents (55%) said that they felt safe on the ward and were not worried or frightened by other patients. However, twenty-two respondents (37%) said that they thought other patients were a potential danger to them, a similar figure to those reported by Mind (2004) and the Royal College of Psychiatrists (2005). Some talked about being worried because of the way various patients looked at them, or because of their bizarre or aggressive behaviour:

“There are patients who sort of either deliberately or through their illness are very aggressive. (.) That’s when I don’t feel comfortable because you don’t want to get involved in something which is going to cause you harm or, an argument breaking out and then, you know, the tension building up.” (C13)

Previous studies (Kumar, Guite & Thornicroft, 2001; Quirk *et al.*, 2004;2006) have highlighted the volatile environment on many psychiatric wards in the UK, with patients either perceiving they are at risk or actually experiencing violence whilst in hospital. Our research confirms this, with just under a half (45%) of the respondents having either witnessed or experienced violence and aggression on the wards, either during their current stay or during previous episodes of inpatient care. Fourteen service users reported witnessing aggression between patients, mainly fighting; twelve reported being the victims of aggression by other patients; and one admitted hitting another patient. These incidents described ranged in severity, from being shouted at, verbally abused, having their clothes ripped, to physical abuse.

## **Intimidation and bullying**

Eleven respondents talked about being bullied by other patients, particularly in relation to being asked for cigarettes or money:

“There’s some in here that keep asking for money. I ain’t got any money to give anybody in here.

Interviewer: “Some are harassing you a bit, are they?”

“Yes. They’re like bullies.” (S3)

Other respondents talked about being coerced by other patients to buy (and smuggle onto the ward) alcohol or drugs for them:

“I get annoyed when I get asked to go and get a drink from the corner shop by the patients. One girl asked me about three or four times last week. She was in the ward and in her room (...) this girl abused the fact that I was short of money; she said, ‘I’ll buy you 20 cigarettes if you go and get me some vodka.’” (C16)

## **Alcohol and drugs on the wards**

Over half (58%) of the respondents reported the use of drugs and alcohol by patients. Many respondents also reported seeing drugs and alcohol being smuggled onto the wards, with some witnessing drug dealing on the ward:

“I think all the drink, like the drinking, the amount of alcohol, things like that, the drugs that come through the ward. Too much is getting through the front door. (.)

Sometimes it's really frustrating when you've got people who (.) who are obviously really slaughtered and (.) they're just like drinking and drinking." (S20)

"There's a problem with drugs. You get the odd person smoking weed and stuff like that on the ward. Sneaking it in the toilets, sneak it around." (S2)

These examples demonstrate clearly a negative consequence of the increased 'permeability' of psychiatric wards (Quirk *et al.*, 2006), with service users' mobility between the outside world and the ward, enabling the fluidity of movement of various substances between the hospital and the outside world.

## **Racism**

Twenty respondents (33%) said they had either witnessed or experienced racism on the wards. Five patients, all Black or Asian, had first hand experience of racism either from other patients or staff members. This was manifest in racial comments and language, or a feeling of racial tension emanating from patients or staff, often subtle rather than overt:

"Oh yes, with patients I get the general "Paki" abuse, those sorts of words they use. There are times you know. But I think at my age I tend to understand that perhaps that person isn't right in the mind." (C13)

Four respondents admitted during interview to being verbally racist towards others on the ward. More positively, some respondents gave examples of staff and patients acting to stop racism on the ward, as demonstrated here:

"There was a guy, I'm not sure whether it was done for a wind-up or whether it was done really from a racist point of view but they kept writing NF [National Front] all

over this guy's wardrobe and leaving notes in his bed and things like that. That was squashed very quickly by other patients.” (C38)

### **Theft of personal possessions**

Unlike Goffman's (1961) description of how patients had their personal possessions taken away from them when they entered the asylums of the past, service users on today's psychiatric wards are allowed their own personal possessions, including clothing, money and toiletries. In our study, 25 respondents (42%) reported that they had property stolen from them, or knew of others who had had their property stolen. The most common items to be taken were clothing, in particular underwear, money, cigarettes and toiletries.

Most respondents felt that having things stolen was part of life on the wards, and that nothing could be done about it. Some even suggested that it was their fault for not locking things away:

“They [toiletries] were on top actually (.) My fault I suppose in one way. I should really lock them up. (...) Since then I have started to lock them up, toothpaste and everything.” (C19)

Some respondents talked about their personal strategies to protect their property:

“I keep my property safe by getting my clothes out of the laundry as soon as possible when they're dry and I lock my money up in one of the lockers provided.” (N33)

“You put your money in Patient Estate. If you don't put your money in Patient Estate it's your own fault, isn't it!” (C1)



### **Patients' personal strategies to keeping safe on the wards**

Over a third of respondents (40%) talked about how they avoided other patients or situations that they perceived to be dangerous. Thirteen respondents used the phrase '*I keep myself to myself*' or similar phrases, as illustrated in the following extracts:

Interviewer: "Overall, how do you keep yourself safe on the ward?"

"By keeping myself to myself." (S3)

"I just don't mix. If I see them [other patients] walking past me, I will just say "Alright?" or something like that but I just don't mix or get myself in a conversation or anything. No, I just want to keep myself to myself." (S16)

However, nearly two-thirds of respondents (62%) said that they felt they could ask staff to help them if something dangerous or frightening happened on the ward. Respondents were reassured when staff were around and confident that they would intervene if there were arguments or conflict. Thirty-eight (63%) respondents said that some staff made them feel more safe than others, sometimes naming particular nurses, with many descriptions of their attitudes and behaviour, including: "*friendly*", "*helpful*", "*they help straightaway*", "*easy to approach and talk to*", "*listen*", "*more empathetic*", "*caring*" and "*reassuring*". Many respondents talked of how staff helped them feel safer in themselves at times of personal distress:

"There's two particular people I get on really well with and that's Peter and Jack (names changed). I had a bath last night and I was hearing my voices telling me to drown myself so Peter sat down outside the door and was asking if I was all right."

Interviewer: “So he was talking to you through that?”

“Yes, I felt really safe then, yes.” (C29)

### **Peer support among patients**

Many service users talked about the support they received from other service users on the ward, with words such as “*camaraderie*”, “*empathy*”, “*support*” and “*friendliness*” used to describe the mutual support experienced on the ward.

“I like them [other service users]. I get on well with them. I find them very helpful. Talking problems through with other patients that you’ve had yourself, it’s quite therapeutic.” (N33)

“They’re understanding. I’ve told a few people about my situation and they’ve said – ‘Oh, I hope you get well soon and we’re here for you if you want us’. So they’re all really nice. I know they’ve all got their own problems but they’re always there for me, as I’m always there for them as well.” (C29)

The quotation from respondent ‘N33’ about the therapeutic benefit of peer support is in keeping with previous research conducted in the USA (Thomas *et al*, 2002). In this study, service users reported that “peer-administered “therapy” was the most beneficial aspect of their hospital stay.

### **Psychiatric wards as places of safety?**

Despite some criticism reported, over half of the respondents (53%) said that they would miss the ward when they left, including the routine and regular meals. Many service users discussed how they enjoyed having people around them to talk to and

being part of a group and having that sense of belonging. Some respondents said that they would miss the ward because they felt safe there, and were frightened about coping outside hospital:

“It’s just frightening going back out there. How can I put it? (pause) I’ve gone well in here (.) I feel safe in here. I got sick out there. I have to go back out there and I could end up getting sick again, but I’ll try not to. Just this fear of going back out there, knowing what’s out there. For me I just need to keep myself safe. The staff here have kept me safe and got me well.” (S2)

For some, discharge meant returning to a life of loneliness, especially if there were no friends and family to return to:

“When I go back home to my flat, I will be by myself most of the time and I like the company of other patients on the ward. I don’t have that many friends.” (S17)

However, concern about leaving hospital was not universal. Eighteen (30%) respondents said they would miss nothing about the ward. Many felt they should not have been there in the first place:

“It will be great. (Pause) Once I’m out of here, I won’t think about this place or nothing. If I did think about it, I would get more depressed and I’d f\*\*\*\*\*’ come back here.” (C12)

## **Discussion**

This study suggests that what respondents most valued from their stay on an acute admission ward was stability and security at a time of crisis in their lives. Anything that

threatened this sense of security, such as fighting between residents, intimidation, bullying, theft, racism, and illegal substances such as alcohol or drugs being smuggled onto the ward, made many of them feel unsafe. Our findings confirm that while the majority of respondents felt safe in hospital, and confident that they could get support and assistance from staff and fellow patients in times of need, psychiatric wards are nonetheless risky environments, where patients may have to devise personal strategies to keep themselves and their property safe.

The most irritating of the everyday trials of being on an acute admissions ward appears to be petty thieving. Theft of personal property was a big problem reported by respondents, a phenomenon relatively unreported in previous studies of acute psychiatric care. Items being stolen were everyday items which patients *have* to bring in with them, such as toiletries, clothing and small amounts of money. While it is important to encourage patients not to bring anything into hospital that they value highly, or which is valuable, patients expressed great irritation that everyday personal items were being taken. As discussed by some respondents, this problem can be at least partly addressed by the provision of lockable wardrobes and cupboards for patients. Individual safes, programmed with a personal security number (such as are often provided in hotels) would also help prevent theft. However access for staff would need to be maintained in order to prevent hoarding of tablets or other items that might present risks.

It is known from previous research that the use of drugs and alcohol on psychiatric wards is an increasing problem in mental health services (Phillips & Johnson, 2003; Quirk *et al.*,

2006). As highlighted by Quirk *et al* (2006), the easy movement of drugs and alcohol between the outside world and hospitals is a tangible example of the increased *permeability* of modern psychiatric wards. Our study confirms these findings, with over half of the respondents reporting the use of drugs and alcohol by other patients. Many respondents stated that this situation was distressing, generating a sense of anxiety and insecurity, as well as a feeling that staff may not be in control of the wards. However, finding a solution to this problem is complex; Phillips (2006) found that people with mental health problems are motivated to use drugs and alcohol for a variety of reasons that do not always relate directly to symptoms or the experience of being mentally ill. Those who regularly use alcohol and/or drugs in the community usually continue to use these substances when they are admitted to hospital. With an ever increasing use of alcohol and/or drugs internationally (World Health Organisation, 2001; European Monitoring Centre for Drugs and Drug Addiction, 2007) it is perhaps unsurprising to find a similar trend in our health care services. Addressing the problem of drug and alcohol use on psychiatric wards is clearly complex and will not be resolved easily.

Regarding racism, our study found that a third of respondents reported having witnessed racism on the wards and five patients, all Black or Asian, had first hand experience of racism whilst in hospital. Racism was experienced both directly and indirectly: directly in the form of racial insults and indirectly with more subtlety, with respondents stating that they can feel a racial tension as a general atmosphere. Perceived discrimination is known to be associated with poorer physical and mental health outcomes and the experience of racism within mental health services is proposed as one mechanism by

which recovery is undermined (Trivedi, 2002). McKenzie & Bhui (2007) claim that the existence of institutional racism in mental health care requires progressive action if services are to serve all the community in a multicultural society.

In keeping with the findings of Quirk *et al* (2004), a key theme to emerge from our study was that respondents devised personal strategies to protect themselves and their personal possessions. Strategies adopted included: staying in their bedrooms as much as possible; not mixing with other patients but remaining cordial with everyone; and observing patients and staff on the ward. However, a more positive aspect of this theme was that the majority of respondents felt that they could ask staff to help them if they felt threatened by another patient or a situation, with the majority of respondents giving positive examples of when particular staff had supported them and made them feel safer, either in themselves, from others, or from a particular situation.

Our study has highlighted the existence of peer support between some patients. Positive outcomes from receiving support from other patients has been demonstrated by some small studies (Felton *et al.*, 1995; Bjorklund, 2000). However, questions remain concerning the 'unique' contribution provided by peers and how tensions around confidentiality and boundaries can be resolved. Our study has also demonstrated that leaving hospital causes anxiety for some patients; previous research has demonstrated that 'discharge grief' may contribute to the high risk of suicide during the immediate post discharge period (Goldacre *et al.*, 1993; Geddes & Juszczak, 1995; Meehan *et al.*, 2006). The need for appropriate discharge arrangements and ongoing support is therefore self-evident.

In Canada, Forchuk and colleagues (Forchuk, Jewell, Schofield, Sircelj & Valledor, 1998) developed the 'transitional discharge model' of care, exploring peer support by 'consumer-survivors' alongside support from hospital staff in the transition from hospital to home for long-stay patients. Transitional support significantly reduced length of hospital stay with no increase in use of services post-discharge, although it was later reported that some people providing peer support experienced role strain and confusion (Coatsworth-Puspoky, Forchuk & Ward-Griffin, 2006). The 'transitional discharge model' was also piloted in Scotland (Reynolds, Lauder, Sharkey, Maciver, Veitch & Cameron., 2004). At the five-month follow-up, patients receiving support from staff and peers experienced significantly fewer re-admissions. There have been no other studies of peer support in the transition from hospital to home in the UK, and none at all in England, where aftercare is provided by community and home treatment teams.

## **Conclusion**

Despite the pessimistic tone of previous reports and studies that have been reported in this paper, many respondents in this study talked about feeling relatively safe and supported by staff and other patients during their stay in hospital, a similar finding to Quirk *et al* (2004). However, some respondents spoke very negatively about their stay in hospital and further research is necessary to discover interventions or conditions that promote a positive attitude towards inpatient stay, particularly for those who resent compulsory admission. The increased 'permeability' of psychiatric wards (Quirk *et al*, 2006) can have negative consequences on patients' experiences of being in hospital,

particularly in terms of the widespread availability and use of drugs and alcohol on psychiatric wards, a phenomenon which many respondents found distressing.

The problem of petty theft on psychiatric wards, rarely reported before in the research literature, is also an area requiring further attention. Our study suggests that there is a strong culture of patients helping other patients on acute admission wards and this is certainly to be encouraged. Where staff have insufficient time to orientate patients arriving on the ward and to assist them during the first few critical days, other patients could take on this role and would probably enjoy doing so. A buddying system might well be an appropriate therapeutic strategy to maximise the sense of security of new admissions, enhance the self-esteem of those who have been there some time and help facilitate the successful transfer of patients from hospital to home. Studies in this area would be highly relevant.

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