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The Nature and Purpose of Acute Psychiatric Wards: The Tompkins Acute Ward Study

Len Bowers
Professor of Psychiatric Nursing, City University

Alan Simpson
Research Fellow, City University

Jane Alexander
Research Assistant, City University

Diane Hackney
Independent User Consultant

Henk Nijman
Professor and Senior Researcher, City University and de Kijvelanden

Angela Grange
Research Facilitator, City University

Jonathan Warren
Director of Service, East London and the City Mental Health Trust

Address for correspondence:

Dr Len Bowers
Professor of Psychiatric Nursing
St Bartholomew School of Nursing and Midwifery
City University
Philpot Street
London E1 2EA

Tel: 020 7040 5824
Fax: 020 7040 5811
E Mail: L.Bowers@city.ac.uk

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ABSTRACT

Background: Acute inpatient care in the UK is being subjected to increasing critical scrutiny, highlighting concerns about content and quality. There is an absence of clarity and consensus on what acute inpatient care is for, adding to difficulties in developing this service sector.

Aim: To define the function of acute psychiatric wards.

Methods: Interviews were conducted with multidisciplinary staff (13 Ward Managers, 14 F Grade nurses, 11 Occupational Therapists and 9 Consultant Psychiatrists), on rationales for admission, their care and treatment philosophy, and the roles of different professionals.

Results: Patients are admitted because they appear likely to harm themselves or others, and because they are suffering from a severe mental illness, and/or because they or their family/community require respite, and/or because they have insufficient support and supervision available to them in the community. The tasks of acute inpatient care are to keep patients safe, assess their problems, treat their mental illness, meet their basic care needs and provide physical healthcare. These tasks are completed via containment, 24-hour staff presence, treatment provision, and complex organisation and management.

Conclusions: Professional education, audit, research and the structuring of services all need to be oriented towards these tasks.

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Keywords: Acute mental illness; risk assessment; healthcare; treatment; assessment.

INTRODUCTION AND BACKGROUND

Modern acute inpatient psychiatry in the UK is beset by problems. A series of recent reports have highlighted difficulties such as: deficits in leadership, clinical skills and risk management (Standing Nursing and Midwifery Advisory Committee 1999); lack of nurse-patient interaction and therapeutic activities (Ford et al 1998); a high level of chaos and crisis-driven care (Sainsbury Centre for Mental Health 1998); and a climate of fear, untherapeutic conditions and overworked staff (MIND 2004). These concerns have been echoed in several research studies. A survey of over a hundred inpatients by Goodwin et al (1999) identified problems with noise, overly restrictive rules, lack of privacy and lack of information about treatment. Walton (2000) collated the feedback of 160 trainees who carried out a period of observation in 22 acute psychiatric wards. She identified a lack of therapeutic direction on the wards with nothing for patients to do; an avoidance of social factors in the generation of mental disorders coupled with a medication-centred view of care; and indifference to patients' civil rights.

For some time the focus of attention of policy makers and researchers has been the implementation of community care and the appropriate service configuration, standards, management, training, etc., to make that successful. Research has largely concentrated on that area, examining and evaluating different models of care (e.g. Assertive Community Treatment, Priebe et al 2003). Attention which has been given to inpatient psychiatry has focused on its replacement with community services (e.g. partial hospitalisation, Wesson et al 2001, or home treatment, Marks et al 1994).

However no service has been able to do without acute inpatient beds at all, and wards have been left to drift with little research, discussion or development.

Coupled with the research and policy focus on community care, there has been a failure to articulate or assert the positive role that acute wards play within the full spectrum system of modern psychiatric services. It is, unfortunately, not easy to do that. Each of the professions involved in psychiatry has differently accented perceptions of acute psychiatry and their role within it. Additionally, there are many different models of treatment competing for attention, including a multitude of psychotherapies, with little empirical evidence to guide the choices of professionals working in the field. To add further complexity, the basic philosophy of psychiatry, and the nature of mental illness are disputed issues, leading to further lack of clarity (Bowers 1998). When attempts are made to define the role of acute inpatient care, there is often further confusion between the endeavour to state what acute care should or could be, and what it is. It is therefore not surprising that recent UK government guidance avoids attempting to provide a statement of the core tasks of acute psychiatry, instead suggesting that each service develops this for itself (DH 2002, p 10).

In order to find a way around these difficulties, we started by asking the professionals working in acute inpatient psychiatry what they did and how they saw their (and each other's) roles and contributions. We sought to arrive at a systematic and clear statement of the nature and purpose of acute inpatient psychiatry, as it operates in the UK in the present day. The data reported in this paper were gathered as part of the Tompkins Acute Ward Study, a longitudinal research project investigating care on

acute psychiatric wards via qualitative and quantitative methods. The study aims to illuminate links between rates of conflict/containment, staff attitudes/philosophies and multidisciplinary relationships. The interviews described in this paper were collected at the outset of the study in order to characterise the approaches of different psychiatric wards.

AIM

To empirically define the purpose and function of acute psychiatric wards through questioning psychiatric professionals about their practice and philosophy.

METHODS

DESIGN

Cross-sectional interview survey of multidisciplinary staff working on acute psychiatric wards

SAMPLE

Multidisciplinary staff (n = 47) in one NHS Trust, composed of Ward Managers (n = 13 [0]), F Grade nurses (n = 14 [0]), Occupational Therapists (n = 11, [3]) and Consultant Psychiatrists (n = 9, [15]). Numbers in the square brackets are of those

who declined to participate, or did not respond to an invitation to do so. Staff from 14 acute psychiatric wards were included in the study, and all Ward Managers, Occupational Therapists and Consultant Psychiatrists were approached and asked to participate. Where there was more than one F Grade on a ward, the person first contacted was asked to participate. The interviews were conducted from October to December 2003, at three inner city hospitals serving a uniformly deprived area. At the time of the study, only one of these hospitals had an operational Home Treatment team and an Assertive Community Treatment team. There were no Social Workers or Community Psychiatric Nurses on the wards (other than visiting individual patients, or attending ward rounds or case reviews). The input from Clinical Psychologists was minimal or absent.

INSTRUMENT

The Operational Philosophy and Policy Interview (OPPI) was developed for this study. This semi-structured interview, used in its baseline form, was used to prompt and guide participants to explore and outline their views on care philosophy, their concept of the purpose of acute inpatient psychiatry, interdisciplinary relationships, team strengths and weaknesses, ward structure, and plans for changes in practice in the coming six months. The interview framework was initially created by the principal investigator (LB) and derived from current knowledge of the field plus his previous research work in the area. It was then reviewed twice by the research team, and suggested changes incorporated.

PROCEDURE

This study received ethical approval from the local research ethics committee. Prospective interviewees were contacted by phone and initially asked if they would participate. Subject to their agreement, a mutually convenient appointment was made. At that time a researcher then explained the study in more detail, gave the subject an information sheet, and asked for their signed consent. Interviews were then conducted, mostly on the wards or in adjacent offices. All interviews were tape recorded and transcribed by an external agency except one (where notes were taken). Following transcription, the accuracy of the transcripts was checked against the initial recordings, and corrections made.

DATA ANALYSIS

Interview transcripts were imported into qualitative data analysis software (QSR N6) and basic factual coding completed (e.g. ward, profession, etc.). All interviews were then read by three researchers (LB, JA and AS), who each created ideas on analytic categories and priorities and then met to agree a strategy for coding. As a preliminary step, interviews were coded to the broad topic areas of the structured interview questions. For the findings reported in this paper, interviewees' responses about who was admitted to their wards and what their problems were, were first reread and then coded into different categories, resulting in the analysis presented under 'rationales for admission' below. Material about the philosophy of care and treatment was then tackled in a similar way, resulting in the analysis presented in the first paragraph of 'the production of acute care'. Finally, questions about the roles of different professionals were categorised into, initially, a large number of different tasks.

However as coding proceeded it became apparent that these tasks could be grouped together under the four overarching means by which acute care is made to happen, and this is the final analysis presented. All coding followed this iterative procedure where the finest grained categories were used at first, then were progressively merged into broader domains as commonalities became apparent.

FINDINGS

RATIONALES FOR ADMISSION

(a) Risk

Most admissions were reported to be emergencies or in response to crises. Most often those emergencies were related to assessments that patients were a risk to themselves or others. The two most frequently cited reasons for admissions were:

1. Risk of harm to self. This incorporated such things as self-harm, parasuicide, self-neglect, vulnerability, suicidal ideation, suicidal talk, and suicide attempts.
2. Risk of harm to others. Words such as ‘endangering others’, ‘homicide’, ‘harming others’, ‘risk to the public’, ‘homicidal ideas’, ‘threats to kill’, ‘homicidal feelings’ and ‘violent behaviour’ were used in this context.

(b) Lack of social support

The degree of risk that resulted in an admission is not considered to be the same for every patient. What matters as well as the degree of risk is the social support available to the patient outside hospital in the community. People who are totally bereft of support, completely alone and/or without resources are more readily admitted. The responses of several interviewees emphasised that admission was a 'last resort', and that community psychiatric services and teams were strongly geared towards keeping people out of hospital and treating them in the community as far as possible. This was considered to be the function of Community Mental Health Teams, Home Treatment Teams, and Assertive Community Treatment Teams. Over occupancy of ward beds was another factor leading to only the most severe and emergency cases gaining admission. However, as one respondent remarked, this huge emphasis on keeping people out meant that when an admission did have to occur, it could be seen in a negative light, as a failure.

(c) Need for respite

Safety was far from being the only reason for admission to an acute psychiatric ward. Respite, in different ways, was another. This could mean respite for the patient from stressful living conditions outside the hospital. Alternatively, it could mean respite for the patient's relatives, neighbours, or local community. In this regard interviewees spoke of patients sometimes being a 'burden to their relatives' or causing their family to be 'at their wits end'. Occasionally it is the wider local community that develops concerns or anxiety about patient's bizarre or difficult behaviour, leading to an admission to provide respite for them.

(d) Acuity

The acuity of the patient's mental illness was the other major rationale for admission. They spoke of patients being 'relapsed or in an acute phase', 'acutely ill', 'severely mentally disordered', 'very unwell', in 'acute crisis', 'thoroughly psychotic', and 'incredibly high'. Mention of these facts was often linked to statements about risk, usually affirming that the risk was because of the acuity of the mental illness. A corollary of being admitted for acute mental disorder linked with risk is that a function of admission is to treat patients' mental disorder. All interviewees were asked what were the main psychiatric conditions they had on their wards, and most answered: psychotic disorders, schizophrenia, paranoia, mania, bipolar affective disorder, depression and personality disorder, in that order. Many went on to add that these presentations were commonly triggered or exacerbated by alcohol or illicit drug use, and they estimated that a quarter to a half of their admissions had some form of substance use co-morbidity. Personality disorders were referred to as being admitted in smaller numbers than people with psychoses, and opinions varied on the utility or benefits of such admissions.

INCONSISTENCY

The routes by which patients are admitted to acute wards are multifarious, with a wide range of different professionals, teams and agencies involved. All of the following were mentioned as, at certain times and in certain places, initiating, facilitating or undertaking the admission of a patient: Community Psychiatric Nurse; Senior House

Officer (preparing to be GPs as well as career psychiatrists); Senior Registrar; Consultant Psychiatrist; Emergency Clinic; Crisis/Home Treatment Team; Community Mental Health Team; Police; Accident and Emergency Liaison Team. As a result, some professionals feel that who gets admitted is not under their control. This kind of statement was made by several nurses, however even the Consultant Psychiatrists felt their control over who appeared on the ward could be limited, with one saying he had very little control, as most admissions came via other routes.

In these interviews, there was little agreement about what constituted an inappropriate admission, with several groups of clients or problems that the majority of staff felt were acceptable work for acute inpatient psychiatry being rejected by other interviewees. Examples included differences over the role of psychiatry in public protection, the precise level of risk necessitating admission, and the utility of admitting patients with drug problems or personality disorders.

THE FUNCTION OF ACUTE CARE

Five themes were found in answers to questions about the treatment and management of patients, indicating the objectives of acute care:

- To keep patients safe, expressed as ‘keeping safe’, ‘making sure they are safe’, ‘keeping the ward safe’ and similar phrases.
- To assess the nature, type and extent of patients’ problems, and patients’ response to treatment, expressed as ‘assessment’ or ‘making a diagnosis’.
- Provide treatment for patients’ mental illness, for example medication.

- Meeting and addressing patients' basic self care deficits and needs, for example 'feeding them' or 'attending to personal hygiene'.
- Providing physical healthcare and treatment, including diagnostic procedures, and the care and treatment of chronic conditions.

The interviews revealed four processes by which these objectives are achieved:

(a) Containment

The means by which patients are kept safe are diverse. Interviewees spoke about the use of sedating medication, de-escalation, and physical restraint in the case of patients who posed a risk to others. For those who were at risk of harming themselves they spoke, for example, of restrictions on the items patients could have with them, observation and searching of their property. Respondents mentioned the need for constant assessment and reassessment of risk so that these activities would be appropriately titrated to the precise degree of risk posed by the patient concerned. Many of these protective actions were therefore individually applied, with, for example, some patients being allowed freely off the ward whereas others were detained within its boundaries for a time.

(b) Presence and presence+

A very large number of interviewees, of all professions, spoke about the need to be with patients, spend time with them, in order to do their work. Medical staff spoke about 'seeing people every week' and conducting 'mental state assessments'. For the

occupational therapists, time was spent with patients in running groups, or in assessment of everyday living skills. Presence was therefore a means of conducting assessments and delivering treatment. However it was the nurses who spoke about being with patients the most, reflecting that they are at hand 24 hours a day, seven days a week.

That presence was the main method by which nurses contributed to the assessment of patients' problems and the outcome of treatment. Whilst engaged in a huge variety of different activities with patients, they would be interacting with them and observing their reactions and behaviour, then communicating these to the rest of the team. The actual treatment of patients also demanded the presence of nurses with them (e.g. the giving out of medication) as did many containment activities previously described, plus the provision of physical health care and dealing with the self care deficits of patients. In fact, it was via the continuous presence of nurses that such things could be adequately delivered, as without 24-hour presence they could not be done at all (e.g. ensuring a patient ate a decent lunch as well as ensuring he had a good night's sleep; or, effectively preventing self-harm).

However, nurses generally meant more than this when they spoke about being with patients, perhaps encapsulated by the word 'presence+'. They had different ways of expressing what they meant. They used words like 'friendly', 'rapport' and 'caring', with one ward manager strongly declaring that 'psychiatry isn't done in the office, psychiatry is done outside where the patients are'. For some nurses this was about 'welcoming' patients and treating them 'like family', whereas for others this was about 'getting to know them' or getting a good understanding of them through

constant contact'. Yet others spoke of 'engagement' with patients, developing a 'relationship' with them, expressing 'respect', 'building up trust', or developing a partnership through 'empowerment' and the provision of 'support'. Thus such presence+ merged into therapeutic relationships and therapeutic treatment in its own right, or could be seen as providing the best possible opportunity for them to occur.

(c) Treatment provision

A variety of different treatments were mentioned, but the greatest prominence was given to medication. The medical staff spoke of prescribing it, the nursing staff of administering and monitoring it, and both spoke of the valuable support and advice they received from pharmacists. Medication was generally the first thing mentioned by interviewees when asked what treatment was given to patients on the acute ward, and was seen as the means by which patients' mental illness was resolved and behaviour brought under control. Some also described the use of sedating medication to manage aggression and arousal. The use of medication was thus central to the task of acute psychiatry. Other physical treatments like ECT and drug detoxification were rarely mentioned.

For nurses, the next most frequently mentioned treatment was presence+, referred to in this context as a 'therapeutic relationship' characterised by a listening to and hearing of patients' distress, problems, and feelings about themselves, their current admission, and their treatment. A variety of psychotherapeutic approaches were mentioned as being used with patients by different professions, including: art therapy, music therapy, psychodrama, counselling, behavioural programmes, psycho-

education, social skills training, and cognitive behaviour therapy. At one end of the spectrum these psychotherapies merged into descriptions of community meetings linked to vague ideas of the ward as a semi-self-governing therapeutic community. At the other end of the spectrum these activities shaded into rehabilitation and training in life skills.

(d) Management, organisation and co-ordination

The activities of the acute wards were supported by an array of professionals of different types, and by a hugely complex organisational and administrative machine. Getting and keeping things organised took a great deal of time and effort from everyone involved. The work was highly necessary, and it was clear that without it, the whole function of the ward would quickly grind to a complete halt.

Admission and discharge of patients were themselves, largely organisational and administrative procedures, requiring complex advance arrangements involving transport, treatment, handovers from community staff to hospital staff (and vice versa), and stressful juggling of bed vacancies between wards involving transfers of other patients or discharges in order to make way for more urgent cases. Once the patient was in hospital, Mental Health Act documentation and procedures had to be carried out, the necessary organisational records maintained, benefits and financial needs attended to, fresh accommodation secured for discharge, the family's needs for information attended to, among a multitude of other administrative and organisational tasks, many involving securing and timetabling visits from other necessary specialist staff (e.g. home treatment team, assertive outreach, specialist addiction unit,

psychologists, art therapists, etc.). The multidisciplinary team were heavily involved in making the system as a whole work to the benefit of patients, and expressed this as ‘co-ordination’, ‘general management’, being a ‘bridge’ or a ‘link’ between the patient and everybody involved, ‘bringing everything together’. This task involved ‘chasing up’ various resources and other professionals, ‘making referrals’, ‘explaining’ things to the patient, ‘communicating’ and ‘providing information’.

DISCUSSION

The study took place in one NHS Trust in a metropolitan inner city area, and this may have led to some bias in the results. For example, the functions of acute psychiatry may be somewhat different (perhaps wider, or with a different emphasis) in rural areas. Although the three main professions delivering acute inpatient care were interviewed, others (e.g. psychologists) were not, and service users were also not interviewed on this topic. A limited number of psychiatrists agreed to be interviewed, and there may be response bias in the findings from that source. Questions were not pursued exhaustively, and a description of the functions of acute psychiatry was not directly asked of respondents. Instead, descriptions of different professionals’ roles, plus criteria for admission and discharge were requested. Hence the findings presented here may be incomplete. For example, the role of staff in professional training was not mentioned by interviewees, but is important and takes time from all concerned. Similarly, ‘hotel services’ were not discussed, as only professional staff were interviewed. However the three professions we interviewed are those with most patient contact in acute psychiatry.

Summarising the purpose of acute inpatient wards enables the definition of what constitutes effective and efficient acute care. An effective acute ward is one where patients are kept safe, accurately assessed, given treatment that works, given basic care that meets their needs, and provides any necessary physical healthcare. An efficient ward is one that accomplishes those targets speedily and at minimal cost. These definitions provide a focus for the management and clinical audit of acute psychiatric wards. They also define the essential outcome indicators for any research that seeks to assess different forms of ward regime or management, or that seeks to assess replacement acute inpatient care with other forms of treatment provision such as home care or day care. By implication, they also specify the training needs of the staff that are employed to provide those services, and could give shape to basic and post-basic education of professional staff.

Acute ward nurses are, at times, criticised for spending time in the ward office (Ford et al 1998). And yet the many demands of patient managements and the wider administration of care translate into a lot of work on the telephone and a significant amount of writing reports, applications, etc., that nurses increasingly complain about (Deacon 2003). Bureaucracy associated with the Care Programme Approach (Simpson et al 2003), Care Management (Parry-Jones et al 1998), and management information systems (Department of Health 1999) add to this burden. Within the scope of existing resources there may be ways of reducing the administrative burden through the streamlining of systems, computerisation, rationalisation, and through training staff in effective and efficient written communication. Further work needs to be undertaken in order to analyse administrative time with a view to its reduction or

delegation, and the consequent release of nursing time for presence+, assessment and treatment. Without such a step, expert qualified nursing staff may remain stuck in the frustrating position of being predominantly case managers rather than direct care providers, a situation that promotes low morale. More than anything else, it is the lack of presence+ that service users complain about, or value when they receive it (Goodwin et al 1999, Rogers et al 1993). However, it should be noted that, as far as we know, little empirical study has been conducted on the association between time spent in direct contact with patients on the one hand, and psychiatric health benefits and required admission time on the other.

This study has demonstrated that there is a huge engine of managerial and administrative activities that supports the main functions of the acute ward, and enables high quality care and treatment. Notwithstanding the comments above about prioritising presence+ for patients, this administration is a valuable component of the provision of acute care, and its place needs to be honoured rather than denigrated as irrelevant paperwork, over-bureaucratisation, or 'red tape'. This is not the first study in recent years to highlight the critical importance to patients of the effective administration of care (Cleary 2004, Deacon 2003).

A fresh starting point is provided for such questions as how many staff are required to run an acute ward. It may be possible to work backwards from the aims of acute care and assess how many staff from what disciplines are required to provide an effective and efficient service. Such an analysis has the potential to highlight significant shortfalls in current service provision. New and more appropriate acuity based workload management systems could also be produced, relevant to this sector of

psychiatric care, replacing those which have been found inadequate (O'Brien et al 2002). Alternatively, it may be possible to consider a complete restructuring of the disciplinary mix providing acute care. An investment in high-level administrative staff might make more professional time available. Traditional boundaries between different professions could be broken down and reconfigured, for example that between occupational therapists and nurses, or between psychologists and psychiatrists. Debate about the future role of psychiatrists is under way in the UK (National Working Group on New Roles for Psychiatrists 2004), and there may also be scope for the involvement of non-professionals and service users and carers (Department of Health 2002). Such reconfigurations and restructurings should be acceptable, so long as the purposes of acute care are effectively met.

Whilst medication is central to treatment on acute wards, and is well evidenced, the diverse and rather idiosyncratic range of psychosocial treatments on offer raises questions about their efficacy, who is responsibility for carrying them out, and the training of those who conduct them. The evidence base for such interventions is generally poor. There is evidence for cognitive-behavioural interventions in this setting (Drury et al 1996a, 1996b), and for group interventions to enhance compliance with medication (Kemp et al 1996), but very little else that has been rigorously evaluated. There is much scope for the development and testing of new interventions in this area.

Physical health problems can be a consequence of mental disorder (mentality 2003), a cause, or a complication (e.g. of a chronic condition like diabetes). The inclusion of the provision of physical healthcare as part of the role of acute psychiatry supports the

medical training of psychiatrists, the common core education of psychiatric nurses with other branches of the nursing profession, and the generic education of occupational therapists. However it may also be possible for nominated staff to develop a specialist role in this regard, allowing others to focus their expertise on other issues.

These findings may also have implications for policy in the provision of acute care. The controversial issue of how many beds are necessary may be viewed differently by asking more specific questions about how many beds are required in order to provide a population with a given level of safety, or how many patients per year require inpatient assessment, etc. Of course such questions can only be answered with both greater knowledge of outcomes, other services provided locally, and the local demography. Nevertheless such questions are much more specific than calculations based on norms and deprivation levels (Glover 1997), or arguments based on over occupancy statistics (Johnson and Thornicroft 1997).

The different points of view on appropriate admissions, coupled with variability in risk thresholds between staff, means different wards have differing patient populations (Flannigan et al 1994). Those differences may be accentuated by locality epidemiological and demographic differences. At one level this means that different wards may have little in common, and variation in wards incident rates (Bowers et al in press), or treatment approaches, for example, may have as much to do with the differing patient populations they serve as it does the strength and quality of their professional staff. At a deeper level these variables introduce a random factor into who gets admitted to a particular ward, with the result that there is considerable

unevenness in the patient population, and the development of a uniform management and treatment response from the multidisciplinary team is made more difficult. Such variability in admissions may also engender conflict within the team. Ways to remedy this situation include a provision of a single route of access to admission (via an admission ward, or through the use of a crisis team), restricting admission decisions to more senior staff, or subjecting those decisions to open review after they have been made.

CONCLUSION

Based on our analysis, a clear statement of the nature and purpose of acute psychiatry is as follows. Patients are admitted to acute psychiatric wards because they appear likely to harm themselves or others, and because they are suffering from a severe mental illness, and/or because they or their family/community require respite, and/or because they have insufficient support and supervision available to them in the community. The tasks of acute inpatient care are to keep patients safe, assess their problems, treat their mental illness, meet their basic care needs and provide physical healthcare. These tasks are completed via containment, 24-hour staff presence, treatment provision, and complex organisation and management.

This definition of purpose can assist in the shaping of training, education, clinical audit, outcome research, skills development, and a potential restructuring of the way in which acute care is delivered. Whilst we recommend that education, audit and research align themselves with what acute inpatient care currently does, we also

consider it timely to begin an informed discussion about what inpatient care could be in future, and how services and professions could be organised to deliver that vision, whatever it may be. However we caution that any vision for the future must describe how the current functions of acute inpatient care should be provided in an alternate fashion, or to say which is to be abandoned, and why. For far too long acute inpatient care has been both neglected and, by implication, devalued. To move forward, a concentration on essentials is required by all professions and at all levels of management.

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