Over the last 10 years, increasing concern has been expressed about the provision of beds for people with acute mental health difficulties. The recent interim report published by Lord Crisp\(^1\) identified five themes:

– lack of alternatives to admission
– demoralisation of staff due to constant crisis management
– patient and carer disenfranchisement
– lack of benchmarking data on the admission process, and
– lack of ongoing staff support and training.

The report identified 91% of wards operating above the 85% occupancy deemed by the Royal College of Psychiatrists as safe.\(^2\) Inadequate step-down accommodation and lack of social services provision has led to long durations of stay.\(^3\) Furthermore, illicit drugs accessible to hospital patients\(^4\) can extend length of stay due to symptom perpetuation.

The skill mix of nursing staff necessary for safe mental health ward care remains uncertain since the National Institute for Health and Care Excellence\(^5\) deferred to NHS England\(^6\) to make recommendations. The risk of a lack of definitive guidance on safe staffing could be significant bed closures and ward centralisation.

Additionally, ward practices will inevitably change with the adoption of the new mental health code of practice,\(^7\) which emphasises the importance of compliance with human rights and equality acts. Legal aid is provided for challenges under these acts, for example on out of area placements, mixed wards, locked doors and lack of privacy.

**Innovations in the UK**

The main response has been ‘new ways of working’ including specific consultants for admission wards, with community services led by other consultants.\(^8\) Although this has produced efficiencies in medical provision, there have been drawbacks, including fractured responsibility for individual patients resulting in differences in approach, for example, in allowing self-directed recovery.\(^9\)

Most services also use assertive outreach teams\(^10\) aimed at keeping ward stays to the minimum and avoiding readmission. To back up this strategy, the government introduced the Community Treatment Order (CTO) requiring readmission if the patient does not comply with follow-up arrangements. However, a review of CTO use concluded that it has been generally ineffective in reducing readmissions.\(^11\) Furthermore, these approaches cannot deal with issues such as inadequate accommodation and carer strain.\(^12\)

**Innovations from overseas**

Toyota production methodology (also known as LEAN) has been used over the last 10 years in surgical wards at Virginia Mason Hospital in Seattle, USA.\(^13\) This involves building uniformity in the pathway of admission aligned with set objectives for various stages; pre-admission, problem formulation, treatment, discharge planning and post-discharge monitoring.

Some mental health services in England, have adapted this system, including designing electronic white boards displaying live data. Typically, there is a formulation meeting within 72 hours of admission when a working diagnosis and treatment plan is agreed with the patient and carers. Thereafter, there is a pre-discharge meeting within 14 days to set a discharge date jointly agreed with the community team, with prompt alerting of social services so that discharge support can be proactively arranged.

This process is supervised at a daily meeting called ‘report out’, attended by medical, nursing, pharmacy and admin staff when progress on this pathway is checked and actions agreed. The most efficient timing of report out appears to be the nursing handover at lunchtime, so that both shifts can input to the process and work on any actions for the next day. Consequently, the weekly ward round is replaced by individual formulation and pre-discharge meetings – more time efficient for carers and visiting staff.

Some services also have a twice-daily bed management teleconference involving all ward managers, led by the duty matron. This meeting includes identifying beds which can safely accept admissions, discussing prospective admissions (including current out-of-area placements) and facilitating discharges. This system is often backed up by complex case reviews of outside area placements,
delayed discharges and community patients at risk of readmission.

Wards also have the option of using the SBARD (situation, background, assessment, risk and decision) handover system. It is designed to make discussions structured, salient and solution focussed. It is a variation of SBAR used in non-mental health specialties such as intensive care, picked up from a USA healthcare provider Keiser Permanente.

The other innovation from Finland is ‘open dialogue’, a system of consultation prior to or soon after admission. Essentially, the patient and his family are seen by two staff members and helped to formulate a narrative to explain the current predicament, with agreement on potential solutions using resources of the patient, staff and family. If there is no family, trained volunteers (typically patients who have been through the process) take this role. This process is used in the USA and Germany with evidence of reduced admissions, reduced bed days and increased discharges without corresponding increase in critical incidents. There are high levels of service user satisfaction.

**A virtual ward?**

There could be collaboration between mental health and housing providers to create a network of supported flats that could accommodate people in crisis – especially those known to services with an agreed risk management plan. This would be an alternative to acute admission, or step down from an acute ward, with supervision provided by community staff on a shift basis, backed up by family and friends.

This system has been used by services catering for homeless mentally ill people. The flats could be accessed by crisis, assertive outreach and early intervention teams. Safe bedrooms under the care of trained foster parents could be envisaged for child and adolescent patients, backed up by a 24-hour community team.

These types of placement need live supervision, which could be provided through the hospital base using Skype consultations with community staff. A service user could also be interviewed by sharing a Skype feed with a community nurse. Therefore, ready access to hospital-based consultant expertise is available. Prescription of drugs with potential cardiac side-effects could be helped by a smartphone recording of finger pulse, which is transmitted as an electrocardiogram recording to the consultant. However, there are medico-legal implications.

An associated issue is observation to avoid harm. Within an inpatient setting, this is carried out by nursing staff – an expensive resource, which could be more productively used for brief psychological interventions. The alternative is closed-circuit television (CCTV) with a trained person observing a number of screens, and alerting clinical staff to intervene when necessary. Arguably this affords more privacy and dignity to a patient than being openly observed. Furthermore, CCTV can be used in the community via a wifi link to the hospital.

It is possible to envisage a patient-held smartcard to transfer and upgrade mental health information including physical problems, current medications, hypersensitivities and advance wishes. This would assist staff to accommodate a wider range of admissions out of hours. This card is similar to handheld obstetric paper records which have been in use for the last 30 years.

**Training and learning needs**

One of the key needs for maintaining quality and safety within wards (virtual or otherwise) is training. This includes updating personal development plans and regular away days for all ward staff to iron out any inter-professional disputes. Furthermore, scenario-based training in managing medical and psychiatric incidents could involve the whole ward team practicing together and receiving prompt feedback. Such a scheme is in operation through Health Education Yorkshire and Humber.

Other skills ward staff would find helpful include motivational interviewing (to help adherence to treatment and avoid compulsions), behavioural activation (adjunctive treatment for depression) and family therapy consultation skills (to apply ‘open dialogue’).

Nursing staff on wards, crisis teams and outreach teams could learn more by being rotated between teams as advised by their personal development plans at appraisal. Furthermore, multi-team learning events (including learning lessons presentations) would be valuable for improvements in quality and safety. Teleconferencing could help this process.

Finally, Schwartz rounds are increasingly used as a means of debriefing ward staff of all disciplines to jointly reflect and learn from day to day stresses in order to achieve better team spirit and maintain compassionate care.

**Conclusions**

This article describes potential solutions to current difficulties in providing locally based, high quality and safe in-patient care. There are usable technologies to assist this process. Furthermore, the concept of virtual wards – common in other specialties – can be applied to mental health, although legal
considerations need to be worked through. Suggestions on the use of reflective team learning are also described.

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References


POEMs

Clonidine beneficial as adjuvant therapy for opioid dependence.

Reference


Synopsis

This RCT among opioid-dependent outpatient volunteers compared clonidine with placebo as adjuvant treatment to buprenorphine. The authors enrolled 208 physically dependent patients aged 18 to 60 years and then randomized the 118 who remained in the program at the end of week 6. Patients were excluded from the study if they had a current psychotic disorder or major depression, a history of bipolar disorder or schizophrenia, current dependence on alcohol or sedatives, cognitive impairment that would preclude consent or self-report, medical conditions that would compromise participation, or the use of contraindicated medications. Buprenorphine treatment began at enrollment with daily dosing observed at the clinic 7 days a week. The patients also received individual counseling once weekly and provided urine and breath samples under observation thrice weekly for drug and alcohol testing. Participants who were abstinent in weeks 5 and 6 were included in the randomization. Clonidine was provided in the clinic once daily with a starting dose of 0.1 mg and increased weekly by 0.1 mg daily to 0.3 mg. Clonidine (or placebo) could be increased or decreased weekly at the discretion of a physician. During the following 12 weeks patients used an electronic diary 4 times daily based on randomly timed prompts to record level of stress, craving, mood, and drug-related environmental cues. Thereafter, the clonidine was tapered off over a period of 14 days and after a total of 28 weeks buprenorphine was also tapered off. Dropouts were relatively high at 28%. Patients in the clonidine group had higher average duration of consecutive days of abstinence (34.8 days [SD = 3.7] vs 25.5 days [SD = 2.7]), which was statistically significant in the patient group with no or low cocaine use during baseline.