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HEAD TO HEAD

Has the closure of psychiatric beds gone too far? Yes

Peter Tyrer believes lack of beds is adversely affecting patient care, but **Sonia Johnson** (doi:10.1136/bmj.d7410) thinks improving community services can take the pressure off wards

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I have been a community psychiatrist for the past 45 years. However, I am now rueing the success of the community psychiatric movement in the UK, where the inane chant of "community good, hospital bad" has taken over every part of national policy. At some point in the steady reduction of psychiatric beds, from a maximum of 155 000 in 1954 to 27 000 in 2008, the downward slope has to level off or rise. The national plan is to make further reductions, but for what reason? A judicious mix of community and hospital services is necessary to provide excellence in mental healthcare,[1] and when this is well integrated bed use falls spontaneously to a steady level.[2] The difficult question to answer is, at what point does a further reduction in beds lead to harm and substandard care?

I believe this point was reached some years ago and that the NHS needs at least 30 000 beds for good psychiatric care with our present treatment options. The evidence for this rests on four stout evidence pillars.

We have run out of successful initiatives to reduce bed use further

There have been many initiatives to reduce psychiatric bed use in the past 40 years. The oldest is crisis resolution and, of these, the best established is assertive community treatment, both of which provide extra resources to treat patients as much as possible without the need for admission. These initiatives tend to be effective when there are too many beds being used, as was the case in the past in developed countries, or at present in developing ones,[3 4] but have no effect when bed usage has reached, or is close to, the minimum.[5 6] The expansion of assertive community treatment was not a success because we already had robust evidence that it had no effect on bed usage[5]; subsequent allegations that it was not being administered properly in the UK[7] were wide of the mark since well resourced community mental health teams were having the same effect on beds and were cheaper.

Risk of preventing admissions is getting too great

The national suicide rate is decreasing, and we would like to think that better mental health services in improving access, reducing stigma, more appropriate treatment, and better follow-up, have contributed to this. One piece of epidemiological evidence stands out; the suicide rate in the first 28 days after discharge from hospital is over 200 times greater for men and over 100 times greater for women than that for the general population.[8] Despite successful, efforts to reduce suicides among inpatients[9] the rate after discharge still remains high, and concern is increasing that overzealous prevention of admission and precipitate discharge are contributing to this, and possibly contributing to increasing suicides outside the hospital system, especially in prisons—the other major institution for mentally ill people.[10]

We have demonised inpatient care by neglecting its function

One of the curious absences of psychiatric research in the last few decades is the lack of interest in investigating good inpatient care. Every inpatient nurse, unless the extra pay for unsocial hours is too attractive to ignore, now yearns to work in the community or anywhere away from hospital. The average acute patient psychiatric ward in inner cities reminds us of the origin of the word, bedlam, with overworked demoralised staff working in an atmosphere of threat interspersed with angry criticism, screaming, and abuse, far removed from the original concept of asylum, a place of refuge.[11] This can be corrected only by making the ward a therapeutic environment again.

Discontinuity of care has been enhanced

One of the consequences of the excessive splitting of psychiatric services is that the notion of continuity of care, whereby core team members stay in touch with patients as they pass through different parts of the psychiatric services, has been lost. It is becoming rare for consultants to remain responsible for their

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patients when they are admitted to hospital, yet this is when continuity is most needed. Admission to conventional inpatient care has been viewed as a sign of failure rather than a springboard to success. The growth of proxy residential services as alternatives to admission is associated with greater satisfaction and much preferred to hospital care,[12] but an important reason for this is because they provide planned and coordinated care with known and supportive staff. This used to be true in old-fashioned inpatient care; its loss has been a disservice to patients.

Throughout the history of psychiatry there has been conflict between the administrative and clinical aspects. The former, the "out of sight, out of mind" policy of the Victorian era, has now been replaced by an "out of hospital, do not mind" one, in which the over-riding prerogative seems to be not to hasten recovery but to hasten discharge. Meanwhile struggling clinicians have to carry out care to the best of their abilities in what are unsatisfactory environments.

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"Has the closure of psychiatric beds gone too far?" is the subject of a Maudsley debate at the Institute of Psychiatry, King's College London (www.iop.kcl.ac.uk/events/?id=1209) on 30 November.

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