

special
articles

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Acute wards: problems and solutions

Alternatives to acute wards: users' perspectives

The move from institutional to community care in the second half of the twentieth century arose in a climate in which civil rights became increasingly prominent, and out of which the modern survivor movement grew (Campbell, 1996). Government policy for mental health services, as set out in Standard Five of the National Service Framework (NSF; Department of Health, 1999), requires that care should be provided in hospital, or an alternative in the least restrictive environment, and as close to home as possible. At the same time, Government policy also attaches increasing importance to the involvement of service users and carers in the planning, delivery and evaluation of services. This paper examines alternatives to hospital care from a user perspective. The problem is that the evidence base for the NSF largely consists of quantitative studies designed to answer questions of concern to mental health professionals. This tells us little about the perspectives of the service user, which is the strength and value of user-led research (Faulkner & Thomas, 2002). Much of what follows is taken from this area, but in addition we describe briefly our own experience of home treatment, which the NSF sets out as one of the main alternatives to in-patient care.

Users' perspectives on alternatives to acute wards

The Audit Commission report, *Finding a Place* (1994), consulted with 10 local service user groups to establish their priorities. Alternatives to hospital in-patient care figured prominently, with requests for 24-hour crisis facilities and out-of-hours contact, the choice of non-hospital-based crisis centres and crisis cards. Many users believed that greater help with employment, benefits and financial problems could help to avoid crises occurring in the first place and thus reduce the need for admission. Other studies, like the Mental Health Foundation's Strategies for Living project (see website, <http://www.mentalhealth.org.uk>), have used a variety of qualitative methods to establish what sort of help service users prefer. *Knowing our Own Minds* (Faulkner, 1997) was a questionnaire survey of the experiences of 401 people who identified themselves as users or survivors of mental health services. Hospital admission was very low on their list of priorities; only 2% of respondents mentioned hospital care when in crisis. The majority of people (45%) in crisis wanted someone to talk to, or non-specific support (27%). Alternatives to hospital care, such as a crisis centre, 24-hour access to services or a place of safety, were mentioned by 5%.

The Sainsbury Centre for Mental Health has recently published the results of a major interview study of service users in the community (Rose, 2001). The project trained over 60 interviewers, all of whom were service users, who then interviewed over 500 service users in the community, at seven urban and rural sites across England. The study thus draws heavily on service users' experience and knowledge of their local mental health services. A significant proportion of subjects had experienced hospital admission in the year before the study. Subjects were asked which of five types of help they would prefer when in crisis. Least appreciated was general practitioner (GP) support (53% averaged across all sites). Over 80% said they wanted face-to-face support from a professional and 70% wanted some form of non-medical crisis service. The difficulty in interpreting the result of this study is that subjects had to make a choice from the five alternatives presented to them, rather than being asked in an open-ended way about their preferences.

The most recent publication from the Strategies for Living team presents a variety of personal accounts of surviving with mental distress. Eleanor Dace's account (Dace, 2001) provides valuable insights into what helps and hinders the processes of coping. Eleanor is a service user who '... cannot yet imagine a time when I might not be ...'. For 20 of her 30 years in the mental health system she was either homeless or in the 'revolving door', with frequent lengthy compulsory admissions. An important part of the process of becoming what she describes as an 'active service user' was the development of a mutually supportive network of friends, who themselves were service users, to whom she could turn for help at times of crisis. Having safe, stable accommodation for the first time facilitated this. This personal account is powerful because it suggests that, for many people, the most valuable alternative to hospital care is to be found in their human relationships and friendships. In this light, statutory services are a poor substitute for solidarity borne out of shared experiences of adversity. Peer support networks bring other practical benefits, such as access to peer advocacy at wardrounds and being able to draw up an advance directive specifying what is helpful and unhelpful about hospital admission, as a starting point for negotiations around care.

Home treatment in Bradford: the value of a social model

The principal alternative to hospital care in the NSF is home treatment, and here we shall outline our own experience of this in Bradford. The relevance of this in a paper on user perspectives is that the Bradford Home



Treatment Service was set up from the outset with a radically different philosophy, with a service user development worker playing a central role in shaping and sustaining this philosophy. The service opened in February 1996 and since April 1999 it has served the inner-city primary care trust (population 147 000). The local community has high levels of unemployment, poverty, poor housing and drug use. In addition, 55% of the population are from ethnic minority communities. The service supports people through crises that would otherwise mean hospital admission, and operates 24-hours a day, 7 days a week, with two staff always on call to carry out assessments and planned and emergency visits. The service user development worker was one of the first team members to be appointed. The aim of the post, only open to someone who had used services themselves, was to provide a user perspective at the heart of the team, to address the issues of power between client and professional. The post-holder (P.R.) participates in review meetings at which clients' care is discussed, provides training and information to the team grounded in the growing body of research and other writings by mental health service users/survivors, and plays an active part in the local (and national) user/survivor movement. He visits home treatment clients from time to time, for example if someone wants to talk about the politics of mental health or opportunities for volunteering in Bradford, or if they simply want to talk to another user. However, his role is primarily about supporting the team to develop and maintain a non-medical philosophy.

The success of the service is fundamentally related to this philosophy of care. The team has tried to move away from the prevailing idea of describing human distress in medical terms and instead it places emphasis on clients' own needs, as defined by themselves. An attempt is made to work within the clients' own frames of reference, including those which conventional psychiatry often regards as 'bizarre' and as evidence of so-called mental illness. Social, cultural and political contexts are taken into account, which means framing distress and human struggles as resulting directly from such factors as racism, poverty, abuse, unemployment, isolation and family conflict. Crucially, diagnostic labels, such as schizophrenia or manic depression, are not used.

The team works on the basis of providing whatever support is needed, stressing the importance of human relationships. The value of unqualified staff is recognised: there are five support workers in the team, who have a wide range of practical experience and who can spend time getting to know clients and giving practical support that is particularly valued. As part of the evaluation by

Bradford University (Cohen, 1999), a questionnaire survey found that 81% of those who responded preferred home treatment to in-patient care and 79% felt they were 'better able to cope' with their problems. In its first 12 months of operation the service achieved a 25% reduction in hospital admission and a further 25% once it became fully integrated with the sector mental health services.

Conclusion

The new Mental Health Act will almost certainly result in an extension of the coercive powers of psychiatry from hospital into the community. In such circumstances the values and philosophy of care deserve to occupy a central position in our thinking about the nature of statutory services, whether in-patient or an alternative. In directing attention to structures of care, the NSF may, inadvertently, have downplayed the importance of philosophy and values of care. User-led research indicates that non-professional support based on the human values of solidarity and companionship are key alternatives to professional services. There are important lessons in this for the nature of statutory services.

Declaration of interest

None.

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