Inpatient Mental health user experiences and service redesign

Rapid summary of recent literature

April 2021

Contents

Summary

This is a rapid summary of recent literature related to adult inpatient mental health services with a strategic redesign focus. It gives a sense of some of the key considerations from the literature that we found. The report has three sections based around the following questions:

1. 'What does good look like' in relation to mental health inpatient and specialist care?
2. What type of care can only be provided in an acute hospital setting?
3. What are published examples of whole system approaches to mental health specialist care?

The key points from section of the report are presented below.

Key points

1. Perspectives on 'what good looks like' in relation to mental health inpatient and specialist care

- Qualitative research about service user experience demonstrated a consistent emphasis on the importance and value of supporting **high-quality therapeutic relationships**, primarily between staff and service users.
- Feeling **safe** on the ward was associated with **engagement** and the significance of the ward as a **refuge** was highlighted. Appropriate management of **risk** was important to staff and feeling safe was important to service users. Service users felt safe when staff were perceived as trustworthy, caring and supportive.
- Service users preferred **persuasion** over coercion where possible, or the reasons for coercive measures to be shared with them to help with feelings of trust and safety. Avoiding negative experiences of coercion and consistent application of ward rules perceived as reasonable was important. An aesthetically appealing, safe and **enabling** environment was required. Provision of **activities** such as art, music and exercise was associated with improved **wellbeing**. The opportunity to connect with nature and feel enabled to make small decisions was comforting.
- There is an opportunity to **increase shared understanding and involvement** between staff and service users about the concept of recovery and expectations and decisions about the care pathway and plan. **Information sharing** with service users could be improved and the timing of this may need to be considered.
- It was suggested that when recovery focused care was high, the quality of care and therapeutic relationships were rated highly. More successful approaches to implementing recovery focused care have **organisational support.**
- Systemic improvements were identified for relating to ward admission and discharge **anticipatory communication and collaborative planning with community services for people who may potentially be admitted** and **better involvement** of the patient and family in the care pathway.

- A **support system** may be required for staff to deliver truly **person-centred practice** and it is crucial that staff have a **workload balance** and working environment that supports autonomy, safety, and **hope**.

2. Types of care provided in an acute hospital setting

- User perceptions about the purpose of hospital in a Scottish context are described later in the document and many themes echo the qualitative literature from question 1.
- It was suggested that interventions to **reduce readmissions** were most successful when **bridging boundaries** between hospital and community, increasing **continuity of care** or increasing knowledge of service users and families.
- Compulsory admission rates can reflect **local factors** such as socioeconomic and ethnic population composition. A review of policy approaches related to mental health suggested the need for a multi-faceted approach within **a structured and integrated model**.
- A **systems-level approach** is suggested to be more successful than a single intervention in **accelerating discharge from inpatient settings to the community**.

3. What are published examples of whole system approaches to mental health specialist care?

- A rapid synthesis of evidence which examined **how well different services work to improve outcomes for people in mental health crisis** concluded that there were important gaps in research and outlined implications for practice. These included alternatives to inpatient care as part of the crisis care concordat four stages of care.
- Specific whole system, crisis care, and ward level approaches from the UK were described in academic and grey literature. These are set out in more detail later in the document.
- From a strategic transformation perspective, service user and carers and hardly reached groups should be involved at a strategic level and at all points of the commissioning cycle to reflect the needs of local communities.
- An equal relationship between physical and mental health should be reflected in planning alongside partnership working in meaningful catchment areas including primary, community and hospital services, A&E and others to support a crisis prevention approach.

Introduction

The [Evidence and Evaluation for Improvement Team](#) (EEvIT) within Healthcare Improvement Scotland's ihub was asked to rapidly summarise literature relating to the following questions:

1. [‘What does good look like' in relation to mental health inpatient and specialist care?](#)
2. [What type of care can only be provided in an acute hospital setting?](#)
3. [What are published examples of whole system approaches to mental health specialist care?](#)

We focused on question 1 and 2 from a (general adult psychiatric) user perspective (where user = service users, staff, carers and families), and question 3 from a related system perspective. We carried out a search for recent research and 'grey' publications and summarise the included papers below. It is important to note this document represents a **rapid summary**, it is not intended to be comprehensive review or represent any appraisal of quality.

More information about other ihub mental health work the can be found on the [Mental Health Improvement Portfolio](#) section of the ihub website.

1. 'What good looks like' in inpatient and specialist care from a user perspective

"Where staff had prioritised making sure new admissions to the ward had received a care plan, diagnosis, and medication, for example, service users all prioritised communication with staff as the most important first intervention. Some staff admitted the constant demands made on them through the repetitive processes involved in acute wards had obscured their value as people, to patients"[1]

Key Points

Literature about user experience and perception findings about inpatient care included the importance and value of:

- communication in **high-quality therapeutic relationships**, primarily between trusted staff and service users
- feeling **safe and enabled in a positive environment** and the appropriate management of **risk** and consistency in **regulation**
- avoiding **negative experiences** of coercion and associated communication
- increasing service user and carer/family **information provision and involvement** in holistic care planning, and decision making, particularly at points of transition including admission and discharge
- having a shared **understanding** of approach to **recovery and supporting** staff to meet identified needs

Reviews of service user experiences

A 2020 meta-review of systematic reviews[2] examined factors influencing inpatients perception of psychiatric hospitals. They identified these factors as relationships on the ward, the ward environment, coercive measures, legal status, autonomy, feeling deserving of care, and expectations of care at admission and discharge. The authors noted that these factors appear interlinked, so that 'striving for excellence' in one domain could have a positive effect on other domains, particularly in relation to developing good quality relationships between inpatients and staff, the most consistent factor reported. It was noted that if there are acute safety concerns or complex care needs, inpatient admission can be a necessary aspect of mental health care and so the need for inpatient wards to be therapeutic is essential. The authors suggest that services may already be aware and striving to improve but for those settings that are 'struggling to create a safe and therapeutic environment' they should start to intervene where appropriate, for example: conducting staff training about communication, making changes to the physical environment, increasing therapeutic activity on the ward to minimise boredom, community teams collaboratively deciding on achievable goals for

treatment prior to admission, and providing inpatients with information and choice throughout their admission regardless of legal status. Studies reported that the opportunity to make small decisions such as choice of meals, snacks, or activities was comforting.

A 2019 systematic review[3] of qualitative research on experiences of in-patient mental health services examined 72 studies from 16 countries and identified four themes that were consistently related to significantly influencing in-patients' experiences of crisis and recovery-focused care. These were: the importance of high-quality relationships, averting negative experiences of coercion, a healthy, safe and enabling physical and social environment, and authentic experiences of patient-centred care. Critical elements for patients were trust, respect, safe wards, information and explanation about clinical decisions, therapeutic activities, and family inclusion in care. The authors suggested that these themes can be used to design and deliver high-quality services. A consistent thread across all four themes was the key role of staff in facilitating a high-quality patient experience, but the authors noted that staff operate within the context of a wider system that needs to support the delivery of care. Good staff and patient relationships facilitated the care pathway and reduced coercive measures. Ward rounds were an important setting for staff/patient interaction. The importance of dignity in communication was raised around coercion, medication and seclusion. Patients wanted the reasons for measures to be communicated and to be addressed professionally. Talking with staff following restraint or being allowed to examine records of the event was considered helpful. Patients valued persuasion over threats of force and coercion. It was reported good communication could support patients' trust of staff and feeling safe.

A 2019 Meta-synthesis[4] of the experiences of people with borderline personality disorder admitted to acute psychiatric inpatient wards identified four explanatory themes: contact with staff and fellow inpatients, staff attitudes and knowledge, admission as a refuge; and the admission and discharge journey. Opportunities to be listened to and to talk to staff and fellow inpatients, time-out from daily life and feelings of safety and control were positively perceived elements of inpatient care. Negative experiences were ascribed to: a lack of contact with staff, negative staff attitudes, lack of staff knowledge about BPD, coercive involuntary admission and poor discharge planning.

A 2020 narrative synthesis[5] examined 12 studies from 7 countries and reported that boredom on inpatient mental health wards is linked to poor patient satisfaction, feelings of frustration and increased incidents of self-harm and aggression, particularly for people detained under the Mental Health Act. A good range of activities such as art, music, computer games, gardening and exercise, was linked with improved well-being.

Experience based co-design

As part of a UK research study[6] exploring the experience of hospitalisation from three perspectives (early intervention in Psychosis service users, their families, and inpatient nursing staff connected with seven inpatient units at two hospitals in the Midlands) an experienced based co-design event involving

50 service users, family members, inpatient and community mental health staff, and managers developed the following action plans:

Identified area for redesign	Action
1. Pathways in and out	a. Develop a "patient journey" flowchart.
2. Providing staff with a rewarding and well-supported role	a. Establish protected time on wards, for staff– patient contact. b. Demonstrate that supervision is embedded within the organization to increase a supportive culture for staff.
3. Communicating with families and service-users	a. Develop effective ways of sharing information with service-users and families (about what is happening with regard to admission, care, intervention, support, and discharge). b. Develop effective ways of involving service users and families in decision making (about what will happen with regard to admission, care, intervention, support, and discharge).
4. Recovery-focused practice	a. Establish a working group to identify a model of recovery that is transferable across services.
5. Creating a positive environment for everyone in it	a. Consistent recreational and activity program. b. Consistent welcome and information for patients and family members. c. Improve signage, colour, and access to designated spaces (e.g., quiet space) in the ward environment.
6. Recognising and sharing good practice across professions and services	a. Create a regular early intervention slot in an existing inpatient meeting and vice versa.

Review of nurses' experiences

A 2017 narrative synthesis[7] of nurses' experiences of delivering care in acute inpatient mental health settings identified three overarching themes, which either facilitated or hindered provision of recovery-focused care: 1) Complexity of the nursing role (clinical care; practical and emotional support: advocacy and education; enforcing aspects of the Mental Health Act. and, maintaining ward safety); 2) Constraining factors (operational barriers; change in patient characteristic; and competing understandings of care); 3) Facilitating factors (ward factors; nursing tools; nurse characteristics; approach to people; approach to work and ability to self-care). The authors suggest that a compassionate system of support is needed to enable person-centred practice and that it is critical to have a work environment is supportive of autonomy, ensures workload balance, and is safe, and which fosters hope and optimism.

Staff experience in transformational planning

In 2016 the Royal College of Nursing Scotland carried out one-to-one interviews with nurses and other partner professionals, and reviewed literature on the reform of Scotland's mental health system and identified some key enablers of transformational change for those planning and leading integrated services, learning from the experience of mental health nursing[8]. They identified key enablers as (reproduced here verbatim):

- Change is well led, managed and funded.
- Health and wellbeing are defined by the individual

- People using services are involved both in decision making about their care and at a strategic level
- Real relationships are developed as the foundation of effective teamwork
- An environment is created which enables people to take risks proactively
- Services have the right staff with the right support and training to meet identified needs
- Integrated care pathways enable people to access the level of support they require
- There are services available for people needing care in the community in times of crisis.

The [mental health crisis care concordat](#) is a national agreement between services and agencies involved in the care and support of people in crisis in England, which sets out how organisations will better work together to make sure that people get the help they need when they are having a mental health crisis.

The concordat suggests effective commissioning ensures that the support and services reflect[9]:
- **The needs of people of all ages and all ethnic backgrounds, reflecting the diversity of local communities**
- **An equal relationship between physical and mental health**
- **The contribution of primary, community and hospital care, as well as other partners**
- **The inclusion of seldom-heard groups, or those that need improved early intervention and prevention.**

It is suggested that this can be achieved through service user and carer involvement in all elements of the commissioning cycle, strategic direction, and monitoring of crisis care standards, and that partnership working is best supported by services working within meaningful catchment areas for example within the same area covered by local Emergency Departments and ambulance services[9].

Examples could include:
- *"effective care pathways from police custody suites and courts for individuals with co-existing mental health and substance use issues.*
- *resources to support a crisis care pathway which ensures patient safety and choice to make sure individuals can be treated as close to home wherever possible. This may also include working with housing organisations, people experiencing homelessness or vulnerable people who are noticed on the rail transport network.*
- *needs of children and young people with mental health conditions, such as self-harm, suicidality, disturbed behaviour, depression or acute psychoses.*
- *a focus on recovery which is demonstrated by measuring outcomes and clearly shown in service specifications, including patient and carer experience and satisfaction data.*
- *effective local safeguarding arrangements in place to prevent or reduce the risk of significant harm to people whose circumstances make them vulnerable."[9]*

2. Care that can only be provided in hospital from a user perspective

> *"Conceptualising [interventions to improve discharge from acute adult mental health inpatient care to the community] from a patient safety, systems-thinking perspective and with an explicit theory of change may make it easier to: 1) describe the specific problem the interventions aim to address; 2) understand the elements of an intervention that are effective to produce the desired intermediate or long term outcomes and c) understand what long term outcomes would indicate an effective intervention."[10]*

Key points

Literature about user perception of the function of care provided in hospital included the importance and value of:

- Users were asked about the purpose of a psychiatric hospital in a Scottish context by the Mental Welfare Commission for Scotland. Themes are described below and many echo the qualitative literature from question 1 and include the importance of a focus on recovery.
- A multi-organisational study in NHS England and NHS Wales found high ratings for quality of care and therapeutic relationships when recovery-focused care was high.
- A systematic review reported that implementation of recovery-orientated practice in inpatient settings is possible, though challenging. Ongoing organisational support for the approach is beneficial.

Views on the purpose of hospital

A 2019 summary report[11] by the Mental Welfare Commission for Scotland of the views of people with lived experience on the purpose of a psychiatric hospital included 205 people via 16 focus groups in Scotland (service user and carer views and a small number of staff). They identified:

- *"When people are ill and need a hospital admission they want a safe place to go to and be looked after. Sometimes they want treatment and medication and sometimes they want a chance to find peace, to be cared for and looked after: to get a break from the responsibilities of coping in the 'real world.' A chance to just 'stop'.*
- *They want to be around loving compassionate people who will listen to them, and help them talk about the things they want to talk about without judging them.*
- *On a practical level, people want a pleasant environment, good food, and adequate facilities and support for visitors and families. They want things to do and places to go outside of the hospital, especially the natural world.*
- *They want support from their peers, but also from staff.*

- *Many people prize the sense of community and belonging that existed in some hospitals some time ago.*
- *They don't want to feel frightened, or to feel too controlled, but equally some people do not want so much freedom that they can take rash decisions about their safety. They don't want to face meaningless rules; instead rules should fit their needs. They want to be sure that they have their rights and needs protected.*
- *Some people would like to be separated from people with addiction issues, and not to have to worry about being exposed to illegal drugs or alcohol on the ward.*
- *They want to feel that they will get better, and benefit from the stay, and do not want to be bored.*
- *They want admissions that last as long as they feel they need them.*
- *They want to be able to participate, and to have a sense that they might heal and recover.*
- *They don't want to be moved constantly and want to be sure that there is continuity and consistency in their care.*
- *They don't want the weekends to be too empty, and don't want to be scared of the thought of admission, or ignorant of what might happen to them during their hospital stay.*
- *Some people would like to see alternatives to hospitals: therapeutic spaces for people in crisis and people who need to retreat from the world.*
- *A small number of people worry that a concentration on hospital care can detract from the non-institutional care that they might prefer.*
- *The reality is that some people's experience does not fit these desires, but some other people have said that care and hospital treatment has improved over the years and that generally they get the treatment and respect they want."*[11]

Implementation of recovery-orientated care in an inpatient setting

A 2020 systematic review[12] indicated that **whilst challenging, it is feasible to implement recovery-oriented practice in hospital based mental health services**. More successful approaches are **multimodal, applied over several years and have organisational support.** Resistance to change from the embedded, biomedical model, staff attitudes towards recovery, and no service-user involvement in the implementation of recovery-oriented practice were the main barriers to implementation.

A 2019 cross national comparative mixed methods study[13] of recovery-focused mental health care planning and co-ordination in 19 acute inpatient mental health sites in England and Wales examined the views of service users, carers and staff in acute inpatient wards on facilitators and barriers to collaborative, recovery-focused care. "*For service users, **when recovery-oriented focus was high, the quality of care was rated highly, as was the quality of therapeutic relationships**. Service users were aware of efforts taken to keep them safe, but despite measures described by staff, they did not feel routinely involved in care planning or risk management decisions. For staff, there was a moderate correlation between recovery orientation and quality of therapeutic relationships, with considerable variability. **Staff members rated the quality of therapeutic relationships higher than service users did. Staff accounts of routine collaboration contrasted with a more mixed picture in service user accounts.**

Definitions and understandings of recovery varied, as did views of hospital care in promoting recovery. Managing risk was a central issue for staff".

A 2016 literature review[14] examined the extent to which a recovery-oriented approach is an integrated part of mental health inpatient settings, as the idea of recovery-oriented practice has led to changes to elements of wider mental health care and organisational developments. Overall, the review found that:

- **staff in inpatient settings had a positive attitude toward the values and principles of recovery-oriented practice, but there were different understandings of 'recovery'**: many staff tended to view recovery in the context of a traditional medical approach centred on medical stabilisation and symptom relief.
- there were difficulties applying recovery-orientated practice as low capacity led to competing demands for staff, which tended to take precedence over the individual needs of patients. High bed occupancy, high acuity levels and quick turnover of patients emphasised a crisis-driven approach which was mostly aimed at medical stabilisation.
- poor levels of engagement, communication, and collaboration between patients and staff appeared commonplace in inpatient settings. This appeared to be reinforced by physical designs and contradictory structures in organisational standards and procedures.

3. Examples of whole system approaches to mental health specialist care

"You can develop as many whizzy new services or amend services that exist, but until you address how people work together you are never going to address the service change you want"[15]

Rapid synthesis of available models of care

A 2016 rapid synthesis of evidence[16] used the crisis concordat 4 stages of care to structure an examination of how well different services work to improve outcomes for people in mental health crisis. **The four stages of care are: 1. Access to support before crisis point, 2. Urgent and emergency access to crisis care, 3. Quality treatment and care in crisis,** and **4. Promoting recovery/preventing future crises.** One review of reviews, six systematic reviews, nine guidelines and 15 primary studies were included. A limitation found across the stages was quality of evidence with a general lack of rigorous randomised and cluster randomised trials evaluating models of mental health crisis care. The authors note *'further high-quality trials conducted in the UK would have a considerable impact on reducing uncertainty regarding what are the most effective models of care for people experiencing mental health crisis'.*

Reported implications for practice included the below:
1. "**Access to support before crisis point:** *Services should ensure that people at risk of mental health crisis receive care with minimum delay, receive quick referral (either through self-referral or building links between services) and that there is equality of access to such care.*
2. **Urgent and emergency access to crisis care**: *Although there is evidence of benefits for liaison psychiatry teams in improving waiting times and reducing readmission this is largely based on uncontrolled studies and a lack of data from the UK.*
3. **Quality treatment and care in crisis**: *Crisis resolution teams (CRTs) are more effective than inpatient care for a range of outcomes, although implementation of this model of care varies across the UK with few teams meeting all evidence-based criteria for good practice. Crisis houses and acute day hospitals appear as clinically effective as inpatient treatment but are associated with increased service user satisfaction.*
4. **Promoting recovery/preventing future crises**: *Effective service models include early intervention services for people with psychosis and other serious mental illnesses, and collaborative care for depression (particularly for people with chronic physical health problems). Effective individual-level strengths-based interventions include self-management and supported employment. There is also some evidence for benefit for peer support (but this needs further high-quality research to validate these findings)."*[16]

Examples of whole system approaches

Lambeth Living Well Collaborative

In 2019 Nesta reported on their website an example of [transformation in mental health services in Lambeth](#) in London[15]. The director of commissioning and colleagues wanted **to change the system from being crisis-dominated to focusing on prevention, early intervention and enablement**.

The *Lambeth Living Well Collaborative* was established, which includes people who use services as well as clinicians, carers, secondary mental health services, voluntary sector providers, primary care practices, and public health and commissioners to radically improve the way mental health services work. They credit regular **'breakfast meetings'** where everyone comes together to solve problems as a group as being a key element of *'an ethos of collaborative working and a collective reframing of what the challenges are'*[15].

They created new initiatives such as more empowered Community Mental Health Teams, a structured programme of peer support, time-banking, a Community Options Team and networks between GPs, social care and mental health primary care. They are now supporting up to 500 people a month, before they reach crisis point, and have seen a 43 per cent reduction in referrals to secondary care, which has reduced waiting times[15].

Vanguard sites

A 2017 report[17] on lessons from the vanguard sites in England, relating to mental health and new models of care, from The King's Fund and the Royal College of Psychiatrists drew on recent research, in particular interviews with leaders, expert groups and key stakeholders. Findings included that local professionals viewed new models of care which aimed to **remove the barriers between mental health and other parts of the health system as being highly valuable in improving care for patients and service users**. It was emphasised that there was still much more to do to fully embed mental health into integrated care teams, primary care, urgent and emergency care pathways, and population health work.

Nine principles for success were developed which were designed to reflect the approach to integrated mental health that key stakeholder groups would like to see implemented through new models of care:
1. The commissioning, design and implementation of new models of care should be consistent with the requirement to deliver parity of esteem.
2. Mental health should be considered from the initial design stages of new models of care.
3. New care models should address and measure outcomes that are important to patients and service users, identified through a process of co-design.
4. New care models should take a whole-person approach spanning an individual's physical, mental and social needs.
5. New models of care should extend beyond NHS services to include all organisations that may impact on people's health and wellbeing.

6. Invest in building relationships and networks between mental and physical health care professionals.
7. New models of care should enhance the provision of upstream, preventive interventions to improve mental health and wellbeing.
8. Every clinical interaction should be seen as an opportunity to promote mental and physical wellbeing.
9. All frontline staff should receive appropriate training in mental health, regardless of the setting in which they work.

Emerging lessons for local system leaders included: **Incorporate mental health expertise into integrated care teams, broaden the scope of mental health, focus on prevention as well as care, develop the workforce, build the right relationships that span system boundaries, co-design and public involvement as a pre-requisite, starting small and learn from experience, test and adapt**.

Policing approaches

A systematic review of effectiveness of current policing-related mental health interventions[18] (such as liaison and diversion, street triage, specialist staff embedded in police contact control rooms) concluded that overall, rather than finding that one approach is more effective than another, the evidence suggests the need for a multi-faceted approach within a structured and integrated model, such as the Crisis Intervention Team model, and that policy makers, service commissioners and providers may wish to review future options.

Understanding variation in compulsory admission rates

A 2017 cross-classified, multilevel analysis[19] quantified the extent to which patient, local-area, and service-setting characteristics accounted for variation in compulsory psychiatric inpatient admission in England. The authors examined data available for 1,238,188 patients and found that, after adjusting for confounders, black patients were almost three times more likely to be admitted compulsorily than white patients, and compulsory admission was greater in more deprived areas and in areas with more non-white residents. Their interpretation of these findings were that *'rates of compulsory admission to inpatient psychiatric beds vary significantly between local areas and services, independent of patient, area, and service characteristics. **Compulsory admission rates seem to reflect local factors, especially socioeconomic and ethnic population composition. Understanding how these factors condition access to, and use of, mental health care is likely to be important for developing interventions to reduce compulsion.'** Whilst we appreciate this level of analysis may not be feasible we have included this evidence to illustrate the importance and value of examining local data and local factors when considering local interventions.

Example of crisis service approach

24/7 Crisis Service

A 2016 paper[20] in the Ulster Medical Journal describes the outcomes of a new Mental Health Crisis Service in a health and social care trust in Northern Ireland covering five council areas. A 24/7 crisis service was required to provide alternatives to inpatient admission, with over occupancy of acute psychiatric inpatient beds and a move to a new unit meaning a reduction of 30 beds compared to 44.

A multimodal, multi-disciplinary service was developed incorporating a high fidelity Crisis Response Home Treatment Team (CRHTT), Acute Day Care (ADC) facility and two inpatient wards. The aim was to provide alternatives to inpatient admission. The medical staff is consistent during the crisis period (inpatient, ADC and CHRTT phases).There was flexibility in placement and step down and respite support for carers.

The CRHTT role is to enhance the person's skills and improve resilience by replicating hospital care in their own home. Functions include:
- Undertake crisis assessments, manage risk and assess level of containment required
- 'Gatekeep' the inpatient beds
- Collaboratively establish management plans
- Increasing support
- Short term prescribing (meds initiation and review)
- Frequent review during crisis (therapeutic intervention, monitoring of progress, carer support)
- Timely discharge

The ADC role is to support the assessment and management of patients in the crisis service. Functions include:
- Inpatients and outpatients observed in a variety of settings
- Close monitoring
- Less restrictive environment
- Interventions (structured activity, psychoeducation, skills training, signposting to community services)

The authors report that data was collected on a monthly basis and the inpatient occupancy rate, total number of admissions and total length of stay decreased. The average inpatient occupancy rate before the new service was 106.6%, admission rate was 48 patients per month and total length of stay was 23.4 days. After introducing the inpatient consultant hospital model, the average occupancy rate was 90%, admissions 43 per month and total length of stay 22 days. After CRHTT initiation they report it decreased further to 83% occupancy, 32 admissions per month and total length of stay 12 days. The authors caution that the Crisis Service still requires evaluation but the model has provided safe alternatives to inpatient care, **and involvement is maximised with patients, carers and multidisciplinary teams to improve the quality and safety of care**. Innovative ideas are described such as a structured weekly timetable and improved communication through regular interface meetings.

Example of ward approaches

Safewards

Safewards[21] is an evidence-based model formulated specifically for use on inpatient mental health wards. It was developed on the basis of research that showed **up to tenfold variation in incidents of violence, restraint and seclusion between different acute mental health wards with similar patient populations**. Six domains underpin the model: the staff team, the physical environment, outside hospital, the patient community, patient characteristics and the regulatory framework.

In a randomised controlled trial[22] on 31 mental health wards at 15 hospitals in nine NHS Trusts within 100 km of central London. Fifteen wards trialled Safewards and sixteen used a different programme. Wards using Safewards reduced conflict by 15% (95% CI 5.7-23.7%) and containment by 23.2% (95% CI 9.9-35.5%) compared with controls. The authors concluded '**simple interventions aiming to improve staff relationships with patients can reduce the frequency of conflict and containment'**.

Improving inpatient discharge to the community

A 2019 systematic review[10] investigated interventions to improve discharge from acute adult mental health inpatient care to the community. Whilst the different interventions and outcomes reported in the literature made drawing overall conclusions challenging, the authors suggest that interventions that aim to reduce people experiencing homelessness are generally effective where they either provide **resources or support to secure accommodation**. Similarly, with interventions that aim to improve treatment adherence, there seems to be some success in introducing **a co-ordinating professional such as a nurse or social worker or using technology to enhance contacts**. The most successful interventions in **reducing readmission aim to bridge boundaries between hospital and community such as increasing continuity of care, service user/family knowledge,community staff on the ward, or ward staff in the community**. Examples include *Community-Based Discharge Planning* and the *Transitional Discharge Model*. The authors note **a systems-level approach is more successful than a single intervention in accelerating discharge**. **Educational interventions appear to be highly successful** in increasing knowledge in both service-users and care-givers and appear to affect readmission, symptom reduction and treatment adherence outcomes.

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