

'Sorry, no beds': a problem for acute psychiatric admissions

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Perceived difficulty in obtaining hospital admission for acute psychiatric patients was investigated in one health region using a self-reporting method. Over 17 months both inner city and rural districts reported a total of 327 episodes of difficulty in finding a bed. One hundred and six (32%) of reported cases could not be admitted, the remainder being admitted to a 'leave' bed, a bed booked for another patient, or elsewhere, solutions likely to compromise care. Attempts to locate a vacant bed required numerous telephone calls and led to considerable delays. Thirty-nine (12%) of the patients were described as particularly ill, but five of them absconded during the prolonged search for a bed, and a further 17 had to remain in the community, pending a vacant bed, including two aggressive and eight suicidal patients. Considerable under-reporting was confirmed. Possible consequences of the situation are discussed.

In recent years consultant psychiatrists on the North East Thames Regional Psychiatric Advisory Committee have reported increasing difficulty in securing admission for mentally ill people in their districts. The committee accordingly asked the authors to gather data on this.

At the time of the study, North East Thames Regional Health Authority covered the north-eastern part of London and all of Essex, serving a population of 3.8 million, the fourth largest in England and Wales. The region comprised 15 district health authorities each serving an average population of 253 000 (range: 112 000–448 000), varying from relative affluence to severe deprivation (Jarman indices: West Essex: –19.34; Tower Hamlets: +54.89). In April 1994 North East Thames amalgamated with North West Thames and now forms part of North Thames Region.

The study

While it was acknowledged that a comprehensive study would have been desirable, the need to obtain results within a short period and with minimal resources led us to adopt a self-reporting method.

In March 1991 100 report cards were sent to the consultant psychiatrist representing each of

the 15 districts on the regional committee. A covering letter asked representatives to explain the project to their senior and junior colleagues and encourage them to complete a card whenever they experienced difficulty in finding a hospital bed for a psychiatric patient.

Information requested on the cards included the district and hospital involved, patient's initials and age, eventual disposal and delay in effecting this, number of hospitals approached and time taken to do this, and name and grade of the responder. There was also a space for comments. The name and address of one of the authors was printed on the reverse of each card to simplify postal return.

After two months, districts which had not returned any cards were contacted by letter and later, if there were still no returns, by telephone. Further batches of cards were despatched to each district at regular intervals, and also on request.

Findings (March 1991–July 1992)

Our initial letter prompted several letters in reply, all reporting major difficulties in admitting patients, and welcoming the study. Comments included "perpetual crisis", bed occupancy regularly exceeding 100% (admitting patients to beds 'belonging' to patients on leave or even setting up camp beds in a ward office), and delays in admitting patients under a section of the Mental Health Act. One respondent stated "in a sense, every psychiatric admission to hospital in this district [warrants completion of a card] on the grounds that patients are almost invariably admitted to a leave bed or another patient is prematurely discharged to make way for a new admission." (A.K. Black, personal communication).

In a 17 month period, 12 out of 15 districts returned a total of 327 cards. Thirty-two (10%) of cards returned related to patients over 65. Of the cases reported, 118 (36%) were admitted to a leave bed, nine (3%) were admitted to a bed booked for another patient, 94 (29%) were admitted elsewhere, and 106 (32%) were not admitted. While we did not include 'placed on waiting list'

as an option, 39 responses indicated that this had been the outcome of patients falling into the 'not admitted' category. Of the 94 patients admitted elsewhere, 80 were transferred to other NHS psychiatric units but seven had to be sent to private hospitals and seven were admitted to clinically inappropriate beds (six medical and one seclusion). This often required numerous telephone calls to an average of 2.0 (range: 1–7) hospitals which took an average of 1.7 (range: 0–3) hours. In some cases similar efforts still resulted in a failure to admit, because other hospitals were also full or they were reluctant to use one of their few vacant beds for an extra-contractual referral.

Thirty-nine (12%) of the responses spontaneously mentioned worrying clinical features: severe disturbance in 12 patients, aggression in three, suicide risk in 11, and the need for detention under a section of the Mental Health Act in 14. Of these 39 cases, 17 patients were admitted within a few hours, five absconded during excessive delays in locating a bed, and the remaining 17 could not be admitted and remained in the community, pending a vacant bed. Of the 22 who were not admitted, severe disturbance was mentioned in five, aggression in two, suicidal ideation in eight, and requiring detention under a section in seven.

When non-returning districts were contacted, all but one reported great difficulty in admitting psychiatric patients. They cited low morale, loss of report cards, or low awareness of the study as possible reasons for not returning cards. Under-reporting was also found to extend to returning districts, and could be quantified in one where episodes were recorded internally. Over a 43 day period, the district identified 27 actual episodes but only two (7%) of these were also reported by card.

Comment

In-patient psychiatric beds will always be needed (Dean & Gadd, 1989), even when there are good community facilities (Hoult, 1986; Stein & Test, 1986), and form an important part of a comprehensive psychiatric service.

In recent years, the literature has commented on difficulties in obtaining acute psychiatric beds and the Tomlinson Inquiry received similar reports. However, ours is the first region-wide study that we are aware of. The results support the impression that, at the time of the study, the demand for acute in-patient psychiatric treatment exceeded the supply of beds in the region.

While methodological factors preclude comparison of individual districts, we were surprised to find confirmation that pressure on beds

extended throughout the region and was not just limited to socially deprived inner city districts.

During the period studied, psychiatric admissions in the region numbered 22 244 (14 914 under 65, 7330 over 65) (NE Thames Regional Health Authority, personal communication). The 327 reported difficulties represent only 1.5% of total admissions, but identified under-reporting would indicate that our figures under-estimate the true severity of the problem.

In spite of this, the fact that a reported 106 patients who were felt to need in-patient care could not be admitted is in itself very worrying. Further, 22 of these patients were identified as posing particular risks and still could not be admitted, with potentially serious consequences.

Two hundred and nineteen (68%) of reported cases could only be admitted by alternate means, for example using a bed on a medical ward or at another psychiatric hospital which could result in sub-optimal care and reduced continuity. The care of an existing in-patient is compromised when he or she is prematurely sent on leave or even discharged to make room for a new admission.

Bed occupancy below 100% is often seen as inefficient but some empty beds are needed to allow for fluctuating demand, especially if no alternative facilities exist (Yates, 1982). For acute psychiatric wards 85% bed occupancy is generally considered the desirable maximum (Hirsch *et al*, 1988). Once bed occupancy approaches 100%, the hospital loses its ability to respond and every subsequent request for admission becomes a crisis for the hospital. This may involve extra work for hospital staff, and our study highlights the excessive time spent by doctors trying to locate vacant beds. Anger and frustration about this situation is conveyed in the cards received. Our study reveals that hospitals resorted to the use of leave beds in 36% of reported cases, something that pushes occupancy rates above 100%, and causes extra work for the ward staff. High occupancy rates associated with difficulty in admitting patients have also been identified in other reports (Patrick *et al*, 1989; Hollander *et al*, 1990).

It is our impression that, since the study took place, the gap between supply of and demand for acute psychiatric beds in the region has widened, with increasing reliance on the private sector.

Recommendations

There needs to be further investigation of this problem, using more sophisticated instruments which allow the levels of need to be quantified. This would contribute to the planning of services which meet minimum standards of safety, taking into account the levels of support available in the community.

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'Elderly graduates' and a hospital closure programme

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A sample of 49 'elderly graduate' residents of a hospital designated for closure were surveyed in 1987 and followed up five years later. Twenty-two patients (45%) had died: the mortality rate was much lower than that predicted by the regional health authority and approximated to that of the general population. All but one of the survivors was living in supported accommodation at the time of follow-up. The majority were satisfied with the move and were receiving an appropriate level of care. However there was significant unmet need for structured activities and companionship. During the follow-up period the survivors had declined in functioning.

The programme of mental hospital closure that began in Britain during the 1980s is gathering momentum. There have been a number of detailed studies of the process and outcome of closure, notably the work of the TAPS researchers investigating the Friern and Claybury closures. However relatively little attention has been paid to the fate of the so-called 'elderly graduates', people admitted to the long-stay hospitals before the age of 65 who have grown old within the hospital. This is surprising since a

majority of the functionally mentally ill residents of these hospitals is over 65 years of age (Clifford *et al*, 1991).

This paper reports a five year follow-up of a sample of 49 'elderly graduates' who were first surveyed in 1987 at Cane Hill Hospital, Coulsdon. Cane Hill was a large mental illness hospital which was planned to close in 1992. The sample represented the long-stay population of the hospital aged over 65 years managed by the Camberwell Resettlement Team (CRT), a multi-disciplinary team responsible for the planning and implementation of successor services for one of the three health authorities involved in the closure. CRT members had specialist interest and expertise in long-term functional mental illness. Planning for elderly patients with dementia was undertaken by the Camberwell Old Age Psychiatry service. The aims of the study were to identify the clinical characteristics of the 'elderly graduate' population and to evaluate the outcome of the closure process in terms of the mortality, disability, quality of life and satisfaction with care of hospital residents.