special articles

Psychiatric Bulletin (2001), **25**, 391

LOUIS APPLEBY

A brighter future for in-patient wards

During April came one of the most important announcements on mental health care since I set up shop at the Department of Health. Thirty million pounds of new money is to be spent on refurbishing in-patient units, starting in this financial year. It is an acknowledgement that some of our wards are bleak and shabby, unsuitable for the care of distressed or disturbed people.

The story was headline news throughout the day. BBC television illustrated it with film of what a ward looks like, although the one they showed was nothing like as bad as some of the ones I have visited lately.

The refurbishment initiative is much more than a makeover. This year, using money that came to health in the Budget, units in every English region, 18 in total, chosen on a 'worst-first' principle, will rid themselves of cramped space and dilapidated decor. But most of the money will come next year and the decisions on which units can expect to get it are yet to be made and can still be influenced.

The announcement is part of a broader plan to improve in-patient care and with it the morale of ward staff. Research on in-patient care will be a national research and development priority. Guidance will be issued on tackling drug misuse on wards. A new group, reporting to the Mental Health Task Force – set up to put the NHS Plan into practice – will report on what else is needed, including treatment skills and training. Added to this is the requirement to remove fixed curtain rails – the means of hanging in many in-patient suicides – by March 2002. Another necessity is to meet the Patient's Charter target on single gender accommodation (not wards, as is often said) by December the same year.

All this is intended to transform in-patient care. It also makes clear that wards are an essential part of a comprehensive local service, not the poor relation. In retrospect the emphasis in the NHS Plan on strengthening community services may have given that impression, but it wasn't the intention.

Instead, the new teams that the NHS Plan has launched nationally are intended to solve a problem: the failings in community care, which have lost the confidence of patients, their families and the public. Too often we lose contact with vulnerable people. Patients who could safely be looked after at home must instead be admitted to wards that are already stretched. It takes too long for young people in their first episode of illness to receive treatment. Hence, new teams offering assertive outreach, home treatment and early intervention.

I don't dispute that the evidence for these services could be better, but the pressing need to solve the immediate problems means taking decisions on the best evidence available, even when this is not complete. It is arguable that we should wait for several major randomised controlled trials and a Cochrane Review on each intervention, but this would take much, much longer. People have criticised the NHS Plan for being ideological, but in fact it is driven by pragmatism.

There is one other point that is often overlooked in the debate about service models, although it is the most important point about the NHS Plan for those of us in mental health. Our status as one of the three clinical priorities will for the next decade open doors on funding for clinical developments and research, on the work programmes of the National Institute for Clinical Excellence and the Commission for Health Improvement and on many other things – the money for in-patient refurbishment is itself a direct consequence. The most important thing about the NHS Plan is that we are in it.

Louis Appleby National Director for Mental Health, Richmond House, 79 Whitehall, London SW1A 2NS

https://doi.org/10.1192/pb.25.10.391 Published online by Cambridge University Press